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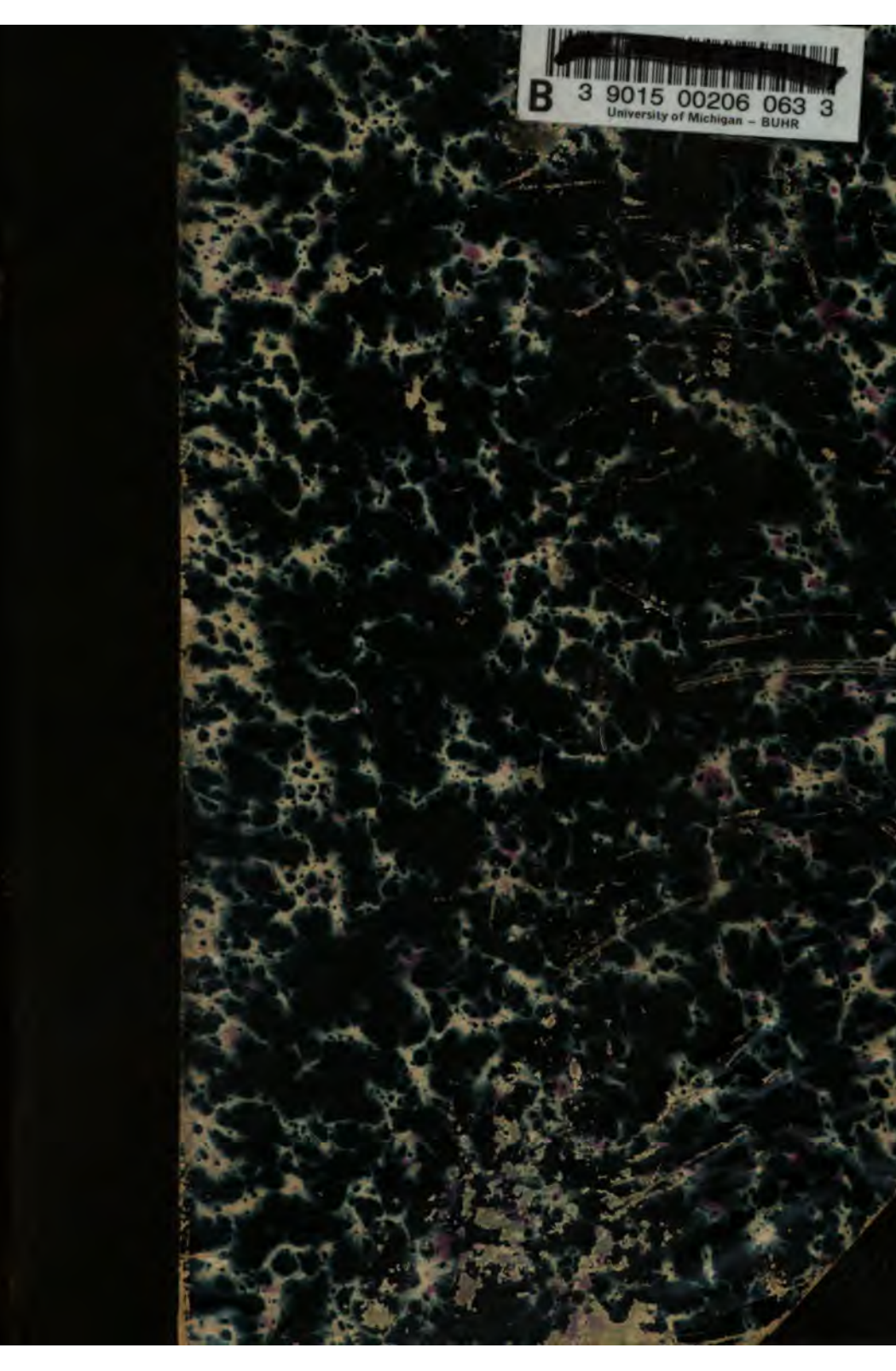
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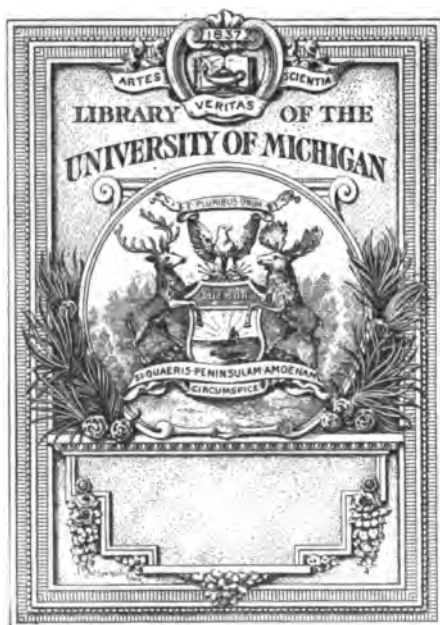
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# THE ATLANTA MEDICAL AND SURGICAL JOURNAL.

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## Original Communications.

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### ADENOMATA OF THE PHARYNX, WITH REPORT OF CASES.

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By L. M. CRICHTON, M. D., ATLANTA, GA.

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"There is nothing new under the sun." Especially is this true as regards adenoids. The brilliant and thorough work of Wilhelm Meyer left but little to be learned by his successors.

In this article I wish to interest the general practitioner in a disease which has not received the attention from him that its great practical importance demands; to give him in a condensed form what is known of the disease, how it is recognized, how treated, and report some cases. Because a man is not a specialist, it is no reason or excuse for his being unable to diagnose at least the simpler forms of disease of special parts.

Many practitioners never interrogate the nose and throat to find out if there is a condition there causing the anæmia, or insomnia, or depressed spirits, or asthma, etc., etc., which they have been treating with but little benefit. That such conditions do exist

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and do affect the general health profoundly, is absolutely beyond question.

SYNONYMS: Adenoids, adenoid growths, adenoid vegetations, hypertrophic posterior nasal pharyngitis, hypertrophy of pharyngeal tonsil, adenomata of pharynx.

The recognition of hypertrophy of the tissues at the vault of the pharynx dates back to the time of William Hunter. In 1862, "Naso-palatine Gland Disease" appeared from the pen of Sir Andrew Clark. Löwenberg and Volotolini wrote of aural complications, in 1865.

The subject was left, however, to be exhaustingly studied both from a clinical and anatomical point of view, by Wilhelm Meyer, of Copenhagen, in 1868. So thoroughly did he investigate the 102 cases on whom he operated, that little of much value has been added to his work.

Hypertrophy of the pharyngeal tonsil is essentially a disease of early life, only a very small percentage occurring after the thirtieth year.

Of Meyer's 102 cases seventy-two were under fifteen years; twenty-one were between fifteen and twenty years; eleven cases were between twenty and twenty-five years.

Of Bosworth's seventy-five cases twenty-one were under fifteen years; twenty-seven between fifteen and twenty; twenty-three between twenty and thirty.

Bosworth accounts for the difference in the average age of his and Meyer's cases by saying: "In many instances the small, glandular hypertrophies found in adult life are identical with those of child life, and are therefore to be treated on the same principles," and "that he has included in his tables a *large number* (italics mine) of those broad, flat growths which constitute the essential condition of many cases of so-called naso-pharyngeal catarrh." Including these cases will of course make the average age greater.

The etiology of adenoids has not been positively settled, the authorities differing. Löwenberg believes the lymphatic temperament to be the "cause of the disease in the very large ma-

jority of cases he has seen." Sajous, "probably traceable to a catarrhal state of the naso-pharynx."

Lennox Browne, citing Hill, agrees with him and associates insanitary surroundings and adenoids, and states: "Lymphatic temperament predisposes to septic inflammation, which may in time be followed by further hypertrophy."

Bosworth, "simply a tendency to hypertrophy under stimulus of repeated colds." Although none of these theories are thoroughly satisfactory, I like that of Bosworth's better than the others.

The various symptoms of adenoids are of course not all manifest even in a typical case. I will give the symptoms in their order of importance: audition, deafness, impaired hearing, otitis media catarrhalis chronica, otitis media purulenta chronica.

The symptom or complication of the ear cannot be too forcibly dwelt upon when we think of the vast importance of this special sense and the ease with which the trouble is prevented, stopped in its course, or ameliorated by a prompt and ready recognition of the cause and the efficient removal of the same. The extreme simplicity of the diagnosis places it in the hands of every practitioner to recognize the trouble, and there can be no possible excuse for a physician who allows a child to become deaf from adenoids, *provided* he has seen the case before very serious impairment of hearing has begun.

Bosworth says, "probably a large majority of ear trouble in children, under the age of twelve years, is dependent upon vegetation at the vault of the pharynx."

Woakes gives ninety-five per cent. of aural complication.

Meyer, in 102 cases, gives aural complications in seventy-two.

Urbantschitsch, in 175 cases, gives aural complications in 130.

Swinburne, in forty-two cases, gives aural complications in twenty-seven.

Bosworth, in seventy-five cases, gives aural complications in twenty-eight.

Respiration: Patient breathes with mouth open. The amount of mouth breathing is in proportion to the extent to which the adenoids have encroached upon the post-nasal space. In some

cases it occurs only during sleep; in others, during the day the mouth is only partly open. In still other cases, breathing takes place through the mouth both day and night. Adenoid patients, as a rule, snore during sleep, and wake in the morning with the throat and mouth dry.

In many instances the child will be brought to you for a "catarrh," nothing else being complained of. You will find in the nose a mucous, muco-purulent or purulent grayish discharge, with masses of desiccated mucus and pus. When you see such a condition in a child *never fail to interrogate the vault of the pharynx*. In pronounced cases the nose is broadened and flattened at its base.

Voice production: Voice has a muffled character; want of resonance; patient "talks thick;" deadness of voice; pronounces m, "eb," and n, "ed." Child is likely to sleep poorly; restless in sleep; may have headaches, disordered digestion, etc., etc.

These adenoid patients, as a rule, seem backward, dull and stupid (varying with amount of naso-pharyngeal trouble); the face has a "blank look," sometimes almost idiotic. This condition comes probably, as Bosworth suggests, from the impaired hearing rather than from mental deterioration.

In a certain number of cases, Fränkel, Bosworth, Chattelier, reflex asthma has been caused by these growths.

Lennox Browne dwells very forcibly on the relation of adenoids to false croup. He says: "In these cases reflex croup and cough are not infrequent; indeed, I believe that in almost all, if not all cases of laryngismus stridulus or false croup, the subjects would, if examined, be found to be mouth-breathers."

He also holds that adenoids predispose to "attacks of diphtheria, of exanthemata and other fevers exhibiting nasal and pharyngeal inflammations."

Diagnosis: With one or more of the above symptoms to direct our attention to the naso-pharynx, a diagnosis is a very simple matter.

The most positive and easiest way to verify a diagnosis from symptoms, and to place its accuracy beyond question, is digital examination. Bosworth objects to examination with the finger



and advises the employment of the rhinoscopic mirror. I can see no good reason for his objection. If the digital examination be made *carefully*, there is no danger of doing harm. To the mirror there are the most decided objections, in that general practitioners, as a rule, are not skilled in the use of the mirror; in many children the examination is impossible, even by a skilled hand, on account of the struggles, gags, etc., of the child. Most children, if you have gained their confidence and are not too abrupt, will allow the finger to be inserted, for the first time, into the naso-pharynx with but little resistance.

Standing to the left side and somewhat behind patient, with right hand press the head lightly against your body, then introduce the index finger of the left hand through the mouth to vault of pharynx and examine it gently. If there be adenoids, they will convey to the bulb of the finger a sensation somewhat similar to that conveyed by the rugæ of the vaginal walls of a nulliparous woman, or, to use a classical comparison, "like a mass of earthworms." Press the finger lightly in direction of the vault; remove the finger, and its tip will be stained with blood. Your diagnosis is now positive, and if your manipulations have been careful, no harm has been done. This is the fimbriated variety.

The second variety is a cushion-like mass with deep, depressions irregularly in its surface, and conveys a corresponding impression to the finger.

Treatment: Radical surgical measures are here most plainly and positively indicated and are fully warranted.

Treatment by medication, as astringent sprays, applications, etc., are not indicated and produce only "a modification of the symptoms. A cure *can* be effected by means of chemical or potential cautery, but it takes many applications and a long course of treatment, and seems to me a very roundabout way to accomplish so simple a result. A number of operations have been devised for the removal of these growths, and every operator of any great repute has invented an instrument or modified one already in use to suit himself.

After a careful study of the different operations and instruments, I believe the means are not of such vast importance, al-

though some are, of course, preferable to others. It is important, however, that the surgeon should be *careful*, know his anatomy, exactly what he intends to do, and that he does it with reasonable skill.

Lennox Browne scraps these growths from the vault of the pharynx with his finger nail. Sajous employs the galvano-cautery snare ; Meyer, a ring knife ; Bosworth, the cold wire snare. Löwenburg, Curtis, Cohen, Schesch and others use the post-nasal forceps.

The question of anæsthesia is one on which the authorities are divided. Some employ an anæsthetic, others do not. The surgeon must be governed by the case and circumstances, and decide the matter for himself. Anæsthetics are not *absolutely free* from danger ; the operation is short and not very painful.

In my own work, if the patient or parents of patient are tractable and willing to submit to some pain, I prefer operating without anæsthesia. If compelled to use an anæsthetic, I would prefer nitrous oxide gas, as used by Lennox Browne. Prognosis is always good ; all the symptoms are relieved. As to audition, if the hearing be much impaired its progress will be stopped and the hearing probably improve. If but slightly impaired, the prognosis for recovery is good. If the ear be not affected at the time of diagnosis of adenoids, the operation, as a prophylactic measure, is indicated and thoroughly justifiable.

#### CASES.

Annette N., age 4 years, kindly referred to me by Dr. McRae. Mother a strong, vigorous woman. Mother said she had noticed an offensive odor to breath, more at one time than at another, and a discharge from nose. Said child slept with mouth open, and kept mouth partly open during the day. Douche had been used with only temporary benefit. Child thin and delicate looking. Face had a "pinched look." Mouth partly open, giving the face a blank expression. Hearing not affected.

On examination of nose, found a greyish discharge and desiccated mucus on septum and turbinateds. On account of age, etc., of child, a post-rhinoscopic examination with mirror was

not practicable, so I made the examination with my index finger. This made positive what I had surmised from history, symptoms and appearance of child—adenoid growths. They were of the fimbriated variety, and almost entirely filled the vault. I explained the condition to the mother, and advised operation, telling her it would cure the catarrh and improve the general health of the child ; she consented to operation.

Put patient on spray of Sol. Dobell, diluted one-half, to get nose clean. One week later, Drs. McRae and Giddings being present, I removed a mass of adenoid tissue from the vault of the pharynx. My method of operating is as follows : Child is held firmly on lap of assistant, arms of patient pinioned by arms of assistant ; gag placed between teeth on right side, and held, as well as the head, by an assistant behind child. Standing in front, I introduce finger of left hand into rhino-pharynx, press uvula and palate up and out of danger. I then introduce post-nasal forceps, closed, along my finger to vault, open them, grasp adenoids, partly cut and partly twist them off. I usually go in five or six times, removing as much as possible. I then introduce my index finger and scrape off what remains.

Considerable blood is lost during the removal of the growths, but the hemorrhage is never serious in the fimbriated variety, ceasing after a few minutes of its own accord.

Although free from danger, four things must, when forceps are used, be carefully kept in mind. The uvula must be kept from between the blades of forceps, else it will be lacerated and crushed. The posterior border of the septum must not be grasped and cut in place of the adenoids. Great care must be taken not to injure the openings of the Eustachian tubes. The mucous membrane must not be stripped from the walls of the rhino-pharynx.

After operation told mother to continue spray. Two weeks from operation reported entire relief from all symptoms. Ten days later, the mother puzzled me not a little by reporting a return of the unpleasant odor to breath. I examined the nose and found a grayish mass in the floor of left nostril, right nostril normal. Decided it was foreign body. It proved to be a piece of

cotton which in some way the child had introduced. It was removed and the breath remained free from odor. Three months after operation there had been no return of any symptom. Child had *improved very much in general health.*

I have reported this case somewhat at length, because it belongs to that class of cases in which a general practitioner is apt to look in the *nose* for the trouble.

The two following cases are very similar to the one above, so I will report them briefly.

A. G., boy, age, eight years. Family history good. Father, a strong German. Said child's sleep was much disturbed. Slept with mouth open and snored. Discharge from nose. Hearing somewhat impaired. Examination. Boy in a very fair general condition. Mouth partly open. Peculiar facial expression, not very marked. Introduced finger into rhino-pharynx and found adenoid vegetations, fimbriated variety. Advised operation. Operated; making two sittings.

Subsequent history showed entire relief from symptoms.

M. D., girl, age, six years. Family history good. Father vigorous. Symptoms almost exactly same as above, with the exception that the child's hearing was more profoundly affected. Examination revealed adenoids. Advised operation. Operated.

Subsequent history showed disappearance of all symptoms, save the impaired hearing; this, however, was improving when case was last seen.

If this article draws the attention of the practitioner to this important class of cases, and aids him in the investigation of the same, it will have served its purpose, if not "*satis verborum.*"

101 Whitehall St.

## CIRCUMSCRIBED TRAUMATIC ANEURISM OF A TIBIAL ARTERY.\*

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By HOWARD J. WILLIAMS, A. M., M. D.

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### LIGATION OF THE FEMORAL ARTERY—RECOVERY.

I wish to present the following case of aneurism as the report of the Section on Surgery of the Macon Medical Association:

J. W. W., white, male, age thirty years, brakeman, while at work in the Central Railroad yards, on the night of November 30, 1889, received a gunshot wound in the calf of the left leg. At the time he was wounded he was standing about eight feet from two men who were fighting, so that his back and right side were exposed to their fire. The ball (a No. 38) entered the calf of the leg on a line corresponding to the junction of the upper and middle thirds of the leg, an inch and a half from the inner edge of the tibia, and making its exit at a point three-fourths of an inch from the anterior edge of the tibia, about an inch and a half below the above line. From the position of the wounds, I should judge that the ball passed between the tibia and fibula from behind forwards and from above downwards.

Dr. C. H. Hall attended him for the primary injury, and says there was very little hemorrhage, the wounds healing nicely and nothing unusual was noticed about the case.

The patient says, two weeks after the injury and after the wounds were united and Dr. Hall had discharged him, he noticed a slight swelling on the inside of the calf just below the wound of entrance. This swelling was soft, but was unattended by pain, throbbing, discoloration or heat. Its growth was rapid, soon reaching the size of half an orange. It then lost its softness, becoming more consistent or doughy.

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\*Read before Macon Medical Association, October, 1890.

About one month after the injury there appeared on the outside of the calf, just above the wound of exit and near the edge of the tibia, a slight pulsating spot, which grew in force and extent and became painful ; but it was not discolored, nor was it accompanied by heat. The pain increased in severity and extent, and was soon accompanied by boring pains in the tibia, ankle and foot. He became soon so disabled that he could only walk with difficulty, even with crutches.

I saw the patient first on January 24, 1890, nearly two months after he was wounded, and through the kindness of Dr. Hall took charge of the case.

At that time the swelling on the inside of the leg was about the size of half an orange, semi-soft and painless ; did not pulsate, and, applying the stethoscope, no sounds could be heard. The pulsating swelling on the outside of the leg was as large as an English walnut ; pulsated synchronously with the heart's action, and a bruit could be distinctly heard. Pressure on the femoral artery obliterated the pulsation and bruit. There was no œdema of the foot, indicating no interference with the return circulation. No pulsation could be felt in the posterior tibial artery in the sulcus back of the internal maleolus. The circulation in this artery was therefore shut off below the internal or semi-solid mass. Pulsations in the anterior tibial and dorsalis pedis arteries could easily be felt.

The wound of exit and the pulsating tumor were under an extensive scar left by a sloughing wound following a dog bite received several years before. This scar gave the parts a glazed appearance, the cicatricial tissues being extremely thin ; and as the pulsation could be readily felt, it looked as though the aneurism was very near the surface and rupture was possible at any moment. The possibility of such an accident was favored by the patient's low general condition from prolonged suffering and anxiety. The necessity of immediate treatment was therefore indicated.

To give the patient all the chances of recovery without resorting to operative interference, I decided, after consultation with Dr. Hall, to employ pressure. I therefore bandaged the

limb from the toes to above the knee with an ordinary muslin bandage and applied a tourniquet to the popliteal artery. The bandage was worn moderately tight continuously, while the tourniquet, tightened sufficiently to stop the pulsation and bruit, was worn for intervals of one to two hours, then relaxed for intervals of one-half to one hour. The patient was kept in bed with the limb in an elevated position. His diet was nutritious, but as dry a diet as it was possible for him to submit to. No medicines, such as iodide of potassium or aconite, were given him, as his general condition was too feeble to permit of further depression.

This treatment was borne persistently by the patient for several weeks with but little benefit. On the 24th of March, however, the pulsations and bruit suddenly ceased, and for three days thereafter they could not be detected. They then as suddenly returned, notwithstanding the fact that the treatment was still continuously pursued, and my hopes that the treatment was successful were sadly broken.

Pressure by the application of Esmarch's bandage suggested itself to my mind, but was objectionable, since gangrene of the parts and hemorrhage might possibly follow, owing to the thinness and low vitality of the cicatricial tissues covering the aneurismal sac. Such an accident might follow immediately on the application of the pressure or during a subsequent treatment by ligation, as has been reported in other cases.

I next thought of trying extreme flexion of the leg on the thigh, but, after eight hours of this method, continuously applied, I abandoned it. This treatment was extremely painful and tedious, the patient saying that he suffered more during that eight hours than during the entire several weeks of the first treatment. Nor did the flexion in any way moderate the pulsations, as the aneurism was too low down to be affected by the position.

After further consultation with Dr. Hall, I decided to ligate the femoral artery at Hunter's canal. Dr. McHatton was requested to see the case with me, as I wished his assistance in the operation. He agreed with me that ligation of the femoral artery would give the best chances of recovery.

March 16, 1890, assisted by Dr. McHatton and Dr. Derry,



the latter administering ether, I ligated the femoral artery at Hunter's canal. Dr. Hall was unable to be present at the operation, owing to sickness.

Every antiseptic precaution was employed. The patient was required on the morning of the operation to take a thorough bath, shave the hair from the thigh and put on clean clothing. Clean bedding, clean towels and thoroughly boiled water were provided. The instruments to be used were placed for five minutes in hot water; our hands were thoroughly washed, first with soap and hot water; our nails trimmed and cleansed and then bathed with bichloride solution. Bichloride solutions for the sponges and douche were prepared. After the patient was placed on the operating table the tourniquet was applied loosely to the femoral in Scarpa's triangle, and he was etherized; the thigh was again washed with soap and water, then with ether, and lastly with bichloride solution (1 to 1,000).

The leg being adducted and flexed upon the thigh so as to bring the inside of the thigh upwards, the course of the femoral artery was outlined. An incision, beginning eight inches above the knee and extending three inches down the thigh, was made through the skin and superficial fascia. The deep fascia was next divided to the same extent on a grooved director, disclosing the fibers of the sartorius muscle. This muscle was pushed inwards, and I felt the pulsations of the artery at the bottom of the wound. The internal saphenous nerve, resting on the artery at this point, was pushed aside; a small opening in the sheath of the artery was made, and an aneurism needle bearing a silk ligature was passed around the artery, hugging the vessel closely to avoid the femoral vein which is here behind the femoral artery. Assuring ourselves that we had the vessel and that no vein or nerve was included, the ligature was drawn up and tied, leaving the ends of the ligature out of the wound. All pulsation in the aneurism was stopped by the application of the ligature. The wound was flushed with bichloride solution and closed with several silk sutures. The surface of the wound was freely dusted with iodoform; several layers of iodoform gauze, 8x8 inches square, covered the parts; next a layer of absorbent cotton was

placed around the thigh, over which was placed a broad strip of rubber protective, and, finally, this dressing was kept in position by several turns of a roller bandage. The foot and entire limb was then enveloped in cotton to preserve the warmth of the extremity, and after the patient was placed in bed, several bottles of hot water were placed around the leg. The patient soon recovered consciousness and rested well.

At 6 P. M. the temperature was 99, pulse 100. Sensation of the extremity was good and the foot felt warm. The next two days (March 17th and 18th) the temperature and pulse remained normal; the color and sensations of the limb were good. The patient, however, complained occasionally of feeling hot flushes pass down the limb from the incision to the toes. The toes looked a little shrunken and dry, but not discolored.

March 19th: Temperature 100.4, pulse 114. Considerable mental depression and dread; complained of pain in the wound on the thigh, occasional hot flushes in the limb; color of limb good; shrunken appearance of toes gone. Feeble pulsations could be felt in the dorsalis pedis artery.

March 20th: Temperature 99.5, pulse, 100. Doing well. At noon was sent for, as it was thought that hemorrhage from the incision had occurred. I found a small bloody stain on the bandage and bed clothes, and on removing the dressings a large blistered surface 8x8 inches was found under the iodoform gauze. This blister had ruptured and, oozing from under the dressings, had given rise to the bloody stains. The incision in the thigh, which occupied the centre of the blistered surface and an area around it of an inch and a half, was not blistered, but was healthy, and primary union was taking place nicely. This wound and the healthy skin around it had been covered by pure powdered iodoform and luckily escaped the irritation of the gauze which had caused the blistering. The blister soon healed under dry iodoform freely dusted on it.

March 23d: Pulse and temperature normal. Removed the sutures. Primary union had taken place except where the ligature hung out of the wound. The solid tumor on the inside of the calf of the leg was rapidly disappearing. No pulsations could

be felt in the aneurism. The pulsations of the dorsalis pedis artery could be distinctly felt.

March 26th: Feeble pulsations of the posterior tibial could be felt in the sulcus back of the internal maleolus.

April 7th: The ligature on the femoral artery came away. In a few days the wound left by the ligature had healed by granulation and the patient was out on crutches.

There has been no return of pulsation at the seat of the aneurism, and the patient is now well and has been at work, without the least inconvenience, for six months.

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## A PLEA FOR HIGHER MEDICAL EDUCATION.

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BY A. B. PATTERSON, M. D., ATLANTA, GA.

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"The Southern Doctors and their Work" is the subject of an editorial in the October number of THE ATLANTA MEDICAL AND SURGICAL JOURNAL. Medical education is a subject in which I have been deeply interested for a period of over twenty-three years, and I cannot let this opportune time pass without contributing a mite to the advancement of a cause in which the humblest citizen should feel a deep and personal interest. The editorial, to my mind, deserves more thought and consideration than I feel will be generally given it. The writer endeavors to encourage the doctors to observe and record their observations, and to help the "Southern profession." There is an air of complaint expressed in these lines, and, I think, very justly. The cause of the lethargy and backwardness in the profession South I do not believe is due to malarial influences operating on the nervous center, as a Washington doctor has so sarcastically suggested, nor is it due to so-called laziness. I am inclined to the view that it is largely due to our incomplete system of medical education and training, and the low standard that has existed in many of our institutions. It seems to me that these evils have

had the effect of bringing into the medical profession, in many instances, an ignorant class of young men, who are wholly unprepared for the noble work before them ; who embark in the medical profession more to elude the plough handles than to elevate and advance the grand profession which is in need of the best talent of our country, devoted to thought and scientific investigation. Thus our ranks have become filled up with an inefficient class, whose sole aim is to eke out an easy existence. The effect has been to keep out the talented and ambitious young men, who fully appreciate the situation and engage in other pursuits. We are all conversant with the skepticism that pervades the mind of the unprofessional to a large class. Leaving out the doctor's individual popularity, one doctor is as good as another. This is an evidence of the lack of confidence in scientific medicine. This lack of confidence has made rich the pockets of the patent medicine men, and is a stumbling block to our advancement. I notice in the last few years there has been a greater demand among the unprofessional for better equipped doctors; they are beginning to recognize this progress in medicine as in other branches. The action of one college in adopting the three-course system, coupled with legislative acts creating a State board of examiners, and their thoroughness in eliminating from our ranks unqualified workers, I believe, has had much to do toward educating the public mind and in awakening a more lively interest in the minds of the profession.

The North is in advance of the South in scientific workers. The reason is found in the fact that their educational advantages are superior; they have equipped themselves with every facility for pursuing scientific investigations.

We have no advantages for acquainting ourselves with the ground work—the fundamental principles that underlie this grand structure of scientific medicine. Let every student who goes out to cope and battle with disease be a practical worker in histology, pathology, last but not least, bacteriology; conversant with the use of the microscope, the art of staining and mounting specimens, the cultivation and isolation of bacteria. Thus equipped the student of medicine becomes an intelligent

observer and recorder, a logical thinker. Whether in the city or country he can press forward to the front, achieve a success that will make his name and work known over the civilized world. Atlanta is the city of the South. Let her educators put their heads together and establish and equip a laboratory that will be second to none in the United States, make a course in histology, pathology and bacteriology compulsory in a regular course of medicine—give to our medical students all the advantages that can be derived by attending medical schools North. With such advantages and training our country, instead of being the refuge of ignorance and quackery, would become a light to the world. The “trash” found in our medical journals would give place to genuine scientific research; there will be more “eggs” and less “cackling” and less complaint.

I echo the plea as expressed in the *Southern Medical Record* of October. “A training school is a necessity. A trained nurse is a luxury.” Then let Atlanta have a training school, and that, too, at once. It would be a waste of time to comment on the advantages of such an institution.

Every member of the profession will heartily approve the suggestion of the editor in saying there ought to be a chair of dietetics in every medical college.

27 Old Capitol Building.

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## MERCURY.\*

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By J. S. TODD, M. D.

Professor Materia Medica and Therapeutics in the Atlanta Medical College, Atlanta, Ga.

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The first lecture was devoted to an exhibition of the various preparations of the metal, their physical and chemical properties, tests, doses, antidotes and history. Mercury has been known to science from the remotest antiquity. Aristotle, who flourished and

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\*A synopsis of four lectures from notes taken by L. B. V. Woolley and E. N. Shaw, students in attendance, session '83-84. Revised and corrected by the Professor up to date, and republished on unanimous petition of class to the Editor of JOURNAL.

wrote four centuries before the Christian era, mentions it. Paracelsus, the father of chemistry, first made corrosive sublimate, and thought in it he had discovered the *Liquor Vitæ*. He died a martyr to his faith; but his ghost is avenged by antiseptic surgery. No drug has been so misused and abused; no other medicine so vaunted and so deprecated; no agent so unanimously commended by one school, and so universally condemned by another; no single one of all the various things and substances used for the cure of disease can claim as many victories over it as mercury; no article used for healing has filled as many premature graves; it is potential with good, but also capable of doing great harm; it is a two-edged sword, wielded skillfully, killing disease; ignorantly, the patient; it is a roaring lion, a huge Leviathan, a veritable Samson. Samson slew a thousand Philistines with the jawbone of an ass; in the hands of asses, calomel has killed a number like unto the sands on the seashore. By the wagging of the jaws of asses against its uses, multitudes, for the lack of it, have died equal unto the stars of the firmament. Byron says of Corinth:

“Many a vanished year and age,  
And tempest breath and battle rage,  
Has swept o’er Corinth, yet she stands  
A fortress formed by freemen’s hands;  
The tempest’s blast, the earthquake’s shock,  
Has left untouched this hoary rock.”

So of mercury, gentlemen, and the length of time it has claimed recognition as a potential agent against diseases has not only hallowed it, but has firmly established it; the electricity generated by the “tempest’s breath” has purified the atmosphere, so to speak, and we see now clearly that which before was viewed dimly, hence not intelligently; the battles fought over it have killed off errors on both sides of the question; the shaking up which we were given by Hahnemann and the Eclectics has caused us to abandon houses builded on the sand, and to-day, firmly established we hope on the solid rock of truth, battling against disease, sickness, suffering and death, I am verily persuaded that the rational uses of mercury are probably more

pregnant with good to mankind than any other drug in our *armamentarium medicorum*. Mercury is to medicine what Homer is to verse:—

“ \* \* The Bard sublime,  
Whose distant footfalls echo adown the corridors of time.”

When opium was in its swaddling clothes mercury had been known for two thousand years. Quinine is a thing of yesterday. It is one—alas! too few—of the drugs capable of entering the blood, grappling with disease and coming off the victor.

#### PHYSIOLOGICAL ACTION.

The fumes of mercury coming in contact with seeds prevent their germination. A solution of corr. sub., 2 parts to the 1,000 destroys the communicability of vaccine virus; applied to roots of plants in soluble form it kills them. It destroys the embryo in the eggs of insects; water contaminated with it is poisonous to the fish and infusoria which live in it. In the neighborhood of furnaces where it is smelted cows abort and other animals lose flesh, become cachectic and frequently die. Men who work in mercury mines, smelt ores containing it, or are engaged in any of the arts that require their constantly inhaling its fumes, or handling it—gilders, for example—become pale, lose appetite, flesh and strength; the nervous system suffers in various ways; notably and most frequently, there is a paralysis *agitans*; the bowels become loose, salivation, alopecia, pustular diseases of the skin, necrosis of the bones, etc., successively supervene, and, finally exhausted, death hurries off the victim to the grave. Mercurial cachexia is the name given to the above train of detailed symptoms. Its prolonged use is destructive to every form of animal and vegetable life; in sufficient dose some of its salts will kill either an elephant or a microbe.

#### LOCAL ACTION.

The acid nitrate is destructive of tissue wherever applied. It is one of our best caustics. Corrosive sublimate, as its name indicates, corrodes and destroys animal tissues. It is escharotic, a corrosive poison; the best of all germicides, because it kills germs when more diluted or attenuated, with less constitutional



and local disturbances, than any other agent of its kind, *e. g.*, carbolic acid, iodine *et sui generis*. The red oxide is also escharotic.

Calomel, on the other hand, is sedative to ulcerated surfaces, causing healthy granulations to spring up, and thereby hastening cicatrization. It poisons, not by local, but by constitutional action. The larger the single dose the greater the immunity from harm. With the corrosive salts this is reversed; though it may cause constitutional or toxic effect when used even as an antiseptic, without local disturbances. One distinctive difference of its poisonous action from those of the other ordinary preparations of mercury is that it induces suppression of urine. I think the red iodide would do the same thing. The chemical antidote to it is albumen, but vomit even after the albuminate is formed as this will be digested. Locally the albuminate is not an irritant, but absorbed, produces toxic effect. The ointment applied to the skin is absorbed into the blood and produces characteristic symptoms. Frictions often occasion local troubles of the skin, especially on those who have a delicate cuticle, but it will do so on the toughest if the place where the friction is practiced is not changed. Its fumes inhaled cause irritation of the mucous membranes lining the air passages, attended by cough and succeeded by systemic effects. Injected under the skin, no preparation yet used has been popular, or pleasant, on account of the irritation, tumefaction, pain, induration and frequently sloughing, which it is apt to occasion. Turpeth's mineral is an irritant emetic formerly much used in croup.

#### CONSTITUTIONAL ACTION.

On the glandular apparatus. It is an universal *stimulant* to glandular secretion, both excretory and secretory. Not a gland in the body, probably, that is not stimulated by its presence. It is a poison, a something foreign to the economy, a substance which must be expelled. Calomel and blue mass act as purgatives by increasing the secretion from the liver, bile being the natural peristaltic stimulant; they also cause the pouring out of more of the pancreatic and other enteric juices. Now, it is a

subject of controversy, and much has been said *pro* and *con*, as to whether mercurials do really increase the secretion from the liver. The results of the investigations of the Edinburg Commission caused some to doubt its action on the liver, others to concur with them fully in its non-action, among the latter the learned Stillé, of Philadelphia.

The remarks by Farquharson are so pertinent on this subject, that I read from his work to you what he says:

"The action of mercury on the liver has provoked a good deal of controversy, and whereas it was formerly held that the biliary secretion was directly stimulated, the experiments of Bennett, and the Edinburg Committee seem to show that, on the contrary, the flow of bile is actually checked or diminished by calomel. Two obvious fallacies underlie these experiments, the first being that the dogs, kept for a considerable time previous, with biliary fistulæ, were so affected, not only by the shock of the operation, but by the resulting inconvenience, general discomfort and gradual starvation, that secretion must have been in a great measure suspended; and secondly, it is well known that a remedy which has no effect on a healthy organ may powerfully modify its condition when in a state of congestion or functional derangement."

The National Dispensatory, one of the best books ever written, even with its abuse of mercury, says: "On the whole the most probable conclusion on this subject is expressed in these words: 'Calomel is not a cholagogue, but diminishes the secretion of the bile.'" The United States Dispensatory says: "As a purgative calomel owes its chief value to its tendency to work on the liver, the secretory function of which it stimulates." Again it says: "The alvine discharges, if clay-colored, are generally restored to their natural hue, whether the liver be torpid and obstructed, as in jaundice, or pouring out a redundancy of morbid bile, as in melæna; the judicious use of mercury seems equally efficacious in unloading the viscus or restoring its secretion to a normal state." One of the most sensible men in England, Fothergill, in his Hand-book of Treatment, says: "Mercury is a notable alterative. It is found in all excretions. It acts upon the flow of bile." Some say it acts upon the liver by irritating the ductus

communis choledochus. It does not act this way, because it is not an irritant. It acts from its peculiar property, in secret and inexplicably. Water puts out fire, but it is made of one substance that is inflammable and another that supports combustion. The water has the inherent power to put out fire, and in the same way mercury has the power to act on the secretions. Now, there is a simple scientific reason why water extinguishes flame, but I don't believe any scientist would have gone about *de novo* making from oxygen and hydrogen—the supporter of combustion and an inflammable gas—the enemy of fire. It has been proven that calomel does not act by irritating the intestines, nor alone by increasing the mucous secretion, but it acts as a cholagogue. If the bile fails to get in the duodenum the patient becomes yellow and is constipated. We know that mercury best restores the color and relieves.

The sensible rank and file of the profession never doubted sufficiently, at least, the cholagogue actions of calomel to abandon its use, when they wished to act on this viscus. I say it stimulates all the glands to increased action. It is not a stimulant in the sense that alcohol or ether is. Calomel is the only diuretic preparation; but squills and digitalis may often be given for their action on the kidneys without increasing the urinary secretion; but the desired result will be almost certainly occasioned if any mercurial is added to them.

Of all the emmenagogues—an unreliable class I admit—the best I know of is Fenner's Tinct. Antacid, which has in every ordinary dose about an eighth of a grain of corrosive sublimate. Mercury is not a diaphoretic, but arsenic cures a number of skin diseases of the squamous variety, attended by dry skin, but the best preparation of it to use is the liquor hydrg. iodidi et arsenitis. Does mercury act on the pancreas? This secretion is essential for the emulsion of fats before they are absorbed. Cod liver oil will frequently disagree with your patient; it will not be digested, therefore do him no good. A dose of calomel, one or two grains at bedtime, if he be scrofulous or tubercular it makes no difference, will quickly rectify this. It is no longer belched up, the appetite and flesh improves; it is digested. Such assimilation could not

take place without pancreatic juice. We must credit the mercurial for its reappearance. The late Joseph Pâncoast taught me that small doses of blue mass and calomel were, by insuring proper secretions and digestion, *tonics*, even in wasting diseases.

The salivary secretion is increased by mercury, so much so that salivation is our dread. Salivation is *toxic* effect, not *therapeutic* result. It is an effort of nature to rid the system of the poison. When the interdental spaces begin to swell, when there is a coppery taste in the mouth, a little soreness in the articulation of the jaws, or tenderness of the teeth when struck together, you have given enough mercury. Here medical action ceases and poisonous results begin.

Its protracted use deranges the digestion, and affects the nervous system in a manner to which sufficient allusion has been made.

It disorganizes the blood, lessening the number of red blood corpuscles, destroying its fibrin, impairing its plasticity, diminishing its salts and albumen, lessening its coagulability and hastening, when drawn, its decomposition.

It is found in all the secretions and excretions from the body and its presence has been detected in all the organs and tissues, bony, muscular, cellular, etc. It causes intractable ulcerations of the skin and mucous membrane of the mouth, periostial pains and even, it is said, nodes on the bones—the hair falls and the nails are sometimes shed. The resemblance to syphilis is so marked as to strike even the most casual observer. The anemia, which is a result of the blood dyscrasia, predisposes to hemorrhages.

Weeks after a profuse salivation it is still detected in the excretions. It is sometimes deposited in the tissues and months afterward, being freed by the exhibition of iodide of potash it has caused ptyalism. A patient once salivated is more easily ptyalized a second time, be there even an interval of years between them; hence I would advise you to always ask your patients when you give them calomel the first time if they ever suffered from its poisonous effects. Children and infants exhibit marked immunity from ptyalism, but remember you may not salivate the child, but worse than that sloughing of the buccal

mucous membrane is often occasioned and the cicatrices formed when these surfaces are healed have led to ankylosis of the maxillæ, necrosis of this bone, etc.

Old cicatrices are often reabsorbed in those under the influence of this metal, and fibrinous exudations disappear. The impoverished state of the blood predisposes to hydrops. The power of resisting cold is lessened, and the predisposition to contract all manner of diseases increases. Is it any wonder that anti-mercurial schools arose, when it was once the orthodox fashion of treatment to salivate for almost every disease that flesh was heir to?

#### THERAPEUTIC ACTION.

So much for its physiological effects, especially when pushed to full action, but now we come to its therapeutic results, when rationally administered. In order to illustrate and keep constantly before you its properties, I have written on the black-board its virtues:

Alterative or catalytic.

Anti-syphilitic.

Tonic.

Anti-phlogistic.

Stimulant.

Purgative (cholagogue).

Sedative.

Anthelmintic.

Germicide.

Diuretic (calomel).

Alteratives are said to produce a salutary change in disease without sensible evacuation; catalytics destroy or counteract morbid materials in the circulating fluid. These definitions make mercury applicable in the treatment of all diseases. (?)

I know of many remedies for syphilis, but am acquainted with but one single agent that cures it, that is an antidote to the syphilitic virus, and that agent is mercury. When I say mercury is the cure for syphilis, I mean what I say, all that I say, and only what is said. Now venereal sores and chancroids are not syph-

ilis, and for them mercury is to be eschewed. I have dealt with disease as something that enters the blood, an individuality, so to speak. Sigmond, the great Vienna syphilographer, says syphilis is dependent on a germ. Such has not been the teaching you have received from some of the older professors here. Some tell you that disease is perverted function, a lesion of enervation; and so it is, but I go a little further and ask what causes the perversion, what induces the lesion? A virus acts in an inconceivably small quantity and reproduces itself indefinitely. It is a living something. The virus from a chancre will reproduce its kind. That there will be discovered a corpuscle, or bacillus syphilitica, I have no doubt. The syphilitic virus is killed by mercury (not only by the corr. sub. when actually applied to the virus, for acids and heat and caustics of all kinds will render the virus incapable of inoculation), but the two will not inhabit the same fluid or tissues. In other words, a man under the medicinal influence (and by this I mean with just enough mercury in him to be apparent, never toxically, that is, salivated, etc.) of mercury for a protracted period, the germs of syphilis will die; they cannot and will not circulate together. Please bear in mind the close resemblance between the mercurial cachexia and syphilis, or else you may substitute for the latter, a disease every whit as fatal and incurable. Mercury is the antidote for syphilis, *primary*, *secondary* and *tertiary*, as they are conveniently classed, and on *clinical grounds*.

This being my position, of course, after I am *fully satisfied* that I have a hard chancre, *chancre*, to deal with, I do not delay a moment to put my patient on some preparation of the God-like metal. I assure myself that I am *correct* in my diagnosis, and then like Davy Crocket, "go ahead." I know this is not the orthodox teaching, but if my house was on fire, even had I built it fire-proof, I should not trust to the flames going out; I should not fear damaging the furniture with water because of this hope. I should begin to extinguish before the flames broke out from the roof. So I think would every sensible man.

Why not treat sensibly, act by the body as we would by the house. No, say some of the modern teachers, there are a cer-

tain per cent. of persons who will escape secondary symptoms, and in the same breath they say it is constitutional from the time the chancre appeared. This is a contradiction. Another objection is, if you were mistaken, the mercury has done the constitution irreparable harm. There is sense in this caution, especially where mercury is used to toxic effect. Others say you are inexcusable to begin the mercurial until secondary symptoms appear. Wait until the man is broken out, enveloped in flames, before beginning, you might injure his constitution; some furniture will be spoiled.

Again it is said the treatment masks and delays secondary manifestations. I believe it will in a certain per cent. prevent them altogether and always mitigate its evidence. My experience in the treatment of syphilis has been very great. I am sure I *generally* know chancre from chancroid, herpes, etc., when I see it, and carefully compare the initial lesion with the history of the case.

But I cannot warn you too much about the caution you should observe in believing patients' statements of the last time they had intercourse. Men, honest and truthful about other matters, will prevaricate when it comes to giving testimony on these matters.

It is better to delay giving the mercurial at first, unless there be *no* doubt at all as to the nature of the infecting sore. Your books are very clear in their descriptions of the differential diagnosis between chancre, chancroid, herpes, etc.; but in practice you will find many, many cases that time and time alone will elucidate. But on the first appearance of secondary symptoms, there can no longer be any room for hesitancy as to the course you should pursue.

I have for the past fifteen years used almost invariably this prescription in primary syphilis, after thoroughly destroying the sore, with nitric acid, or the acid nitrate of mercury. It was handed down to me by my fathers in medicine, Drs. H. G. Tate and A. W. Griggs:

R. Tinct iodinii, . . . . . 3 iij.  
Hydg. corr. chlo., . . . . gr. viii.  
Spt. frumenti, . . . . .  $\frac{3}{4}$  xii.

M. et. sol. Sig.—Teaspoonful after meals, with water.



Watch the gums, for you want medicinal action, *not toxic*. If it disturb the bowels, add tinct. opii. This is kept up for from three to six months, and if no secondary symptoms appear lessen the dose of mercury, and substitute for the iodine the iodide potash in from five to twenty grain doses, according to circumstances. Continue this for from three to six months. Then iodide potash alone, or with some tonic for six months after the last symptoms of the disease.

Patients will ask you naturally, "How long will I have to continue medicine?" when they first apply to you for treatment; tell them for six months after you and he are sure he is well. He will be pretty sure to then ply you with the query: "When will that be?" Say to him, God in Heaven only knows. The iodide of potash is a *remedy* for some of the manifestations of syphilis that has no equal. I would not be without it. But be not deceived, when you see a syphilitic node melt away before it like a snow bank before the summer's sun, into the erroneous conclusion that the patient is cured. That *symptom* of syphilis has been relieved—an ugly, jagged-edged, foul-conditioned ulcer, under its healing power, cicatrizes; but bear in mind that you have only "filmed and skillmed the ulcerous sore; rank corruption mining all within still infects unseen."

Mercury, and it alone, so far as I know, can eradicate the disease. Opium will alleviate the pain of a malarial neuralgia, but quinine is the antidote to the poison. It has long been known to clinicians that under the beneficent influence of this drug, syphilitics gain flesh, color and strength; but it was only recently demonstrated by Dr. Keyes that the number of red blood corpuscles was actually increased in those suffering from syphilis, after they were brought under the gentle influence of mercury. Physiological experiments could never have demonstrated this fact. Mercury is not the only medicine that acts clinically in a manner totally at variance with physiological deduction. The prescription which I have given I do not insist on at all; so your compound contains mercury, that will be sufficient, and you may give it by the mouth, by inunction, hypodermically, or by inha-

lation. In the old tertiary cases, of course cod liver oil, food and regimen are essential. My first care, if the patient be so broken down as not to be able to take mercury, is to build him up so that he can take it, and you will be surprised often how much sooner he can bear it than you are aware. In this disease, as previously alluded to, in minute doses it is a tonic, hence probably always indicated, be the state of the system ever so low.

Now mercury will not cure every case of syphilis, neither is every case of any disease amenable to any treatment. Quinine is universally spoken of as a specific against the malarial poison. Yet people die every day from miasmatic emanations, quinine administered to the contrary notwithstanding.

I cannot speak too highly or commend too strongly mercurial fumigation in obstinate cases, especially where the syphilides are troublesome. I use thirty grains of calomel at each bath. It is not generally practiced, because the idea has gotten out that an expensive apparatus is necessary. All that is needed is a large blanket, a cane bottom chair, a pan of hot water and three bricks, one cold, the other shot: One of these latter, and on which the calomel is heaped, place on the cold, which is to prevent burning the floor, the other to put in the basin to keep up its heat and the supply of vapor as the water grows cold. (Here was demonstrated to the class a simple proceeding.)

The patient should wrap up in this blanket and go to bed, not putting on his night clothes until the sweating ceases. The happy results of the mercurial vapor baths in inveterate syphilis are among my greatest medical triumphs. I have given to one patient as many as thirty baths. I never salivated any one by administering mercury in this way.

Mercury is indicated in inflammation of all varieties. Inflammation causes constipation, lessens the excretion of the skin, kidneys, the tongue is foul, there is torpor and sluggishness, mental and corporeal, effete matters are retained in the blood, etc. This pathological process causes an increase of the fibrin of the blood. Mercury decreases that constituent. It is anti-phlogistic; it destroys that which inflammation creates; it puts

to work the emunctories which the phlogosis has paralyzed. As an anti-inflammatory agent it may be thus compared with veratrum or antimony and blood-letting. The immediate effect of bleeding is mechanical; that of veratrum or antimony, nervous; that of mercury, hæmetic.

Blood-letting weakens the force of the heart by diminishing the pressure on the vessels; antimony or veratrum diminishes the pressure on the vessels by weakening the force of the heart, and mercury does both of these things by impoverishing the blood. Antimony and veratrum arrest inflammation by reducing the pulse; mercury reduces the pulse by arresting inflammation;" antimony or veratrum direct their powers to the effects; mercury to the cause.

This extraordinary power of the drug has led to its almost universal use, for there are few diseases in which there is freedom from inflammation. When we did not understand the natural course of diseases as we do now; when we were afraid that if left to itself it would never tend to recovery, blood-letting and mercury held full sway. We know better now, and have found out that the large majority of diseases, with proper nursing, etc., run their course without fatal result. But we must not go too far in tentative treatment; we must do something more than make a correct diagnosis and prognosis. Mercury is a stimulant to the glandular organs, excretory and secretory. Nature, always conservative, is helped by this drug in her effort to rid the system of the *materies morbi*.

Calomel is one of the very best purgatives, but you should always see that it acts on the bowels; if after eight or ten hours catharsis is not occasioned by a full dose, give a saline or castor oil. In beginning the treatment of dysentery it is especially indicated. In hemorrhoids, especially those brought on, as is so often the case, by constipation, a mercurial is a very necessary ingredient in the laxative that you prescribe—for this anatomical reason; the hemorrhoidal tumors when recent are the results of congestion in the hemorrhoidal plexus of veins; these veins empty into the mesenteric; these into the portal vein; the latter vein as you know ramifies in the substance of the liver as

an artery, and in this gland the dam is found. Mercury by relieving this congested organ, permits of the disgorgement in the far off rectal vessels. Calomel in 1 to 2 grain doses every 2 to 3 hours, in general anasarca, attended by scanty urine, will re-establish kidney action, but should not be used until the failure of other medicines, for obvious reasons.

At one time mercury in conjunction with opium was regarded as essential in the treatment of serous inflammations, especially peritonitis, but it was supposed to have been shown that the opium and not mercury is the curative agent, but with salts curing peritonitis, as it undoubtedly does, may it not be that the mercury preventing the opium from constipating was, after all, the healing factor? In syphilitic iritis, of course belladonna is indispensable, but if there be a disease in which you are excusable for salivating it is in this. In acute inflammation of the liver I would not give mercury, on the principle of not working a sick horse. Calomel, in small or large dose, has been for time immemorial used as a sedative to the stomach in obstinate vomiting. I would not recommend it until other means had been exhausted, for these reasons: Nutrition is already impaired by the starvation which the non-retention of food has occasioned; except in syphilis it is not tonic, and never a reconstituent one; and again, if it did not purge I should fear toxic effect; and purgation would but increase the debility and weakness which is the natural result of this derangement of digestion. The best of all anthelmintics is calomel and santonine, followed by oil and turpentine. The santonine may often be left out and still the parasites are expelled. As a purgative for children calomel has no equal in the long list of remedies of this class.

Few Southern doctors have written text-books; the Northern and European writers tell you that a mercurial purge in the treatment of malarial disease is unnecessary. Salines do just as well, say they, followed by quinine. They may in New York or Philadelphia, but you will find that if you do not "prepare the system" for quinine with calomel, the exacerbations will recur with provoking and mortifying frequency. The "preparation" which the mercurial gives I believe to be this: it insures the *absorption* of the

anti-periodic, for unless it gets into the blood the *palmellæ*, which cause the congestions, etc., are not killed. Fothergill in his Handbook of Treatment, makes (what I consider) the following sensible remarks: \* \* "In convalescence the occasional use of alteratives is proper and beneficial. It often happens that a steadily progressive recovery is suddenly clouded by a state of feverishness, a foul tongue, loss of appetite and general *malaise*. Under these circumstances it is a good plan to give some pil. calomel, et colicinch co. at bedtime, and some citrate magnesia in the morning, or to give a few grains of calomel with some jalap or scammony in the morning, if patient be seen in forenoon. A gentle action on the bowels generally restores the condition to what is to be desired. But it must not then be conjectured that it is the mere purgative action which is the whole matter; like results will not follow if the *mercurial* be omitted."

We come now to its use in diphtheria. In fourteen years of practicing medicine I have not seen many cases of diphtheria. I did not call all sore throats or membranous deposits diphtheria. I would advise you not to do so. You will get notoriety, but not reputation. You will become notorious among the people in a small area for curing diphtheria, but physicians will know you are an ignoramus, if you say you cure every case of diphtheria. Every case I had in these fourteen years died. I doctored them *secundum artem*, exactly as the books said, iron, stimulants and chlorate of potash. They all died scientifically. Mercury was withheld as a poison. I had been taught that the disease began with debility, and that the doctor who would give mercury was worse than a heathen. I concluded not to follow longer this treatment. I would advise you not to follow the lead of him who carries you to disaster. I remembered seeing an article in the London *Lancet* in 1871, which told of twenty cases of diphtheria cured by calomel and the bicarbonate of soda. I was disposed to ridicule it at the time. There was an article read before the American Medical Association upon corrosive sublimate in the treatment of diphtheria by Dr. Pepper. The writer details a case that was given large quantities hypodermically. The case was in *articulo mortis*. It got well. It was the only case he had. Dr. Gray and myself had a

case together nine years ago. Though the patient was nearly gone, we were afraid of the mercury treatment. We knew of it and spoke of it. We treated the case *secundum artem*. It died. There was another child with diphtheria to which we were called. We gave it two grains of calomel every two hours. For awhile it did not act. But in thirty-six hours there was a tarry discharge. We gave that child as much as fifty grains of calomel. It got well. We kept up the stimulants, milk and punches all the time. In the same family in a very short time there was another child taken. It was treated like the last; it was given one hundred grains; it recovered. Some of the best physicians in the city said we were mistaken in our diagnosis; that if there had been diphtheria mercury would have killed them. They said if this had been true diphtheria, there would follow the sequela, albuminuria, aphonia, etc. This case had all of these. I have treated six cases in the past two years in this way, and five have recovered. I expect to continue this treatment until I can find something better. As diphtheria is at first a local disease, the application of corrosive sub., 1 to 1,000, will kill the germs and prevent systemic infection, and should always be practiced when practical. Such is, has been and will be my plan in treating the disease. It may be that from these deposits on the tonsils and the pharynx and all in the throat, these germs drop down and the patient swallows them. They are then absorbed and carried over the whole economy to be deposited wherever there is an abraded surface. Since these articles have been written much has been said on this subject. If this, the germ theory of diphtheria, is not true, another reason for its use is the formation of heart clot, which is one of the greatest dangers in this disease. The heart is stopped. Mercury defibrinates the blood, and without fibrine these clots could not be. We thus avoid one of the great and dangerous results of diphtheria; and lastly, another reason why I approve the treatment, and it is one of the very best of reasons, under the approved method of medication my patients died, under mercury they recover. No case was salivated. You will please observe that the principle of treatment is the same; alcohol and the chlorides are both germicides, so is mercury. In the treat-

ment of diphtheria with mercury, I object to such tremendous large doses as 20-40 grains, because we do not have the signal of danger, it does not salivate. Small doses, two or three grains every two or three hours is sufficient. Put it down as a golden rule, learn it by heart, and don't forget it, that ptyalism is not a therapeutic result, but a toxic effect.

Typhoid fever is treated by the Germans on what they call the eliminative plan during its first week. It is very often exceedingly difficult to tell for a week or ten days whether the fever you have to deal with be typhoid or not. Their plan is to give ten grains of calomel every other morning for a week. I am not prepared to indorse this plan fully, but the following good results that would accrue, recommend it. The large dose insures purgation, which so early in the case will do no harm, so ptyalism is obviated. There is always an effort on the part of nature to throw off disease; calomel stimulates all the emunctories. If the disease be caused by germs it is emphatically germicide. I dare not deny that it occasionally aborts it, though I cannot say we have any specific as yet for the typhoid poison; in malarial localities the calomel and quinine at first are due the patient. Often if they are omitted your patient will go into a typhoid condition, when at first he, by their judicious administration, would have recovered in a few days, and been saved weeks of suffering and perhaps death.

I have found that unless I gave calomel, after relieving a child of ordinary croup with emetics, the disease was very apt to recur for three nights in succession.

The saving of life, the mitigation of suffering and the shortening of time lost after operations, from antiseptis, a term synonymous with cor. sub., makes this agent the equal almost of anæsthesia to the surgeon.

Locally, calomel is used in various diseases; so is the ammo. precip. hydrg., red oxide and corr. sub., which it is not necessary for me to enumerate in this place, although it was fully entered into before the class. Neither do I deem it profitable or interesting to my readers to mention all the diseases in which we use mercury, its modes of administration, etc. The following pre-

scription I have found so useful in parasitic diseases of the skin that I give it: R.—Hydrg. corr. chlo. grs. iv; tr. iodinii, tr. canthar. spt. vin. aa. q. s. ad. ʒi. M. ft. sol. Sig. Paint on with a camel's hair pencil. Pruritis vulvæ and ani are often occasioned by parasites, corr. sub. 2 grs. to the oz. of alcohol killing them, the itching ceases. 1 to 250 corr. sub. is a parasiticide generally strong enough.

In conclusion I desire to make this remark: Three of our most used and most highly valued medicines are germicides, viz., alcohol, quinine and mercury.

We are on the eve of great discoveries; a bright day is dawning upon us, after the long night of doubt and uncertainty about the *modus operandi* of drugs; a great flood of light is being shed on this subject by such men as Lister, Pasteur and Koch. I verily believe that the time will come when, owing to the advances in the healing art, the average age of man will be three-score years and ten, and lo! the day is near at hand!

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## ONE HUNDRED CONSECUTIVE CASES OF SKIN DISEASE.

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### III

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By M. B. HUTCHINS, M. D.,  
Lecturer on Diseases of the Skin, Atlanta Medical College.

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[NOTE.—In preceding article, on page 726, in directions for dose, following prescription in middle of page, 1 oz. should be 1 drachm.

Eczema of scrotum, two cases. First, that of a druggist, aged forty-two. Left half, and posterior surface of scrotum and anterior portion of perineum affected. Thickening marked, and there were deep fissures, many the result of scratching, for the severe itching which was present. Patient, however, complained more of "burning" than of itching. There was some "oozing" from the fissures. Here and there were a few large papules, excoriated and slightly discharging.



On the scalp there were a few sero-crusts or excoriated, discrete lesions, itchy and aggravated by scratching. Sensations, at times, of dizziness and weakness.

A "pigment" composed of—

R. Olei. cadonii, 3ii.  
Ether, sulph.,  
Sp. vini. rect., aa 3ii.

M.

was applied to scrotum and perineum, but found ineffective. Then the "*Salicylic, zinc and diachylon ointment*," as already described, was ordered applied on cloth, and held by suspensory bandage during the day. The ointment was to be frequently rubbed on scrotum and perineum at night, especially if itching recurred.

Within four days the fissures were healed, skin was quite soft and smooth, but now more itching and less "burning." (The "burning" was in the fissures.) There was no relapse, but the patient excoriated the scrotum several times by scratching. I may here say that itching is the most prominent and persistent subjective symptom of eczema. In a month the patient was well enough to return to his home in Florida. The treatment of the scalp was as will be given under another head, but was effectually counterbalanced by the industrious use which the patient made of his nails.

Second of scrotum; gentleman of thirty-five, also from Florida. Skin but slightly thickened and presenting a faint "glazed" appearance. Symptoms chiefly subjective, itching being severe, especially at night. (At base of penis and on right buttock irregular, reddish segments of circles, suggestive of "ringworm." Not treated.) Ointment, as in case one, did not relieve itching, and the patient was not seen again, having returned to Florida at the time he began treatment. Ointments seemed to have been improperly made, at first, and finally he seemed to find nothing satisfactory, and probably is still itching.

Eczema of the foot, one case, car inspector, aged thirty-four. Present five months despite all treatment. On back of the small toes of the left foot, over their base and the anterior half

of skin covering metatarsal bones, sharply defined above, thickening, slight redness, scaling and here and there a denuded point from which oozing occurred. Itching present at times. Bromidrosis also present. Disease had been aggravated by bathing in salt water.

R. Ac. salicyl., gr. xv.  
Magnesiæ carb., gr. x.  
Ungt. zn. ox., ʒi.

M.

Sig.—Apply on cloth and bind in place.

This produced immediate improvement, and after all appearance of “activity” in disease subsided, *pix. liquida* ʒi was substituted for *magnesia carbonate*. Itching, which had been very persistent, was relieved by the addition to the ointment of ʒii *spir. camphoræ*. Patient’s foot was entirely well in a month.

Of “general” eczema, or that occupying the greater part of the skin surface, first case that of a married woman, aged twenty-two. Disease began on hands about four weeks previously as papules and vesicles, and when seen almost the entire skin surface was covered with pale red papules and vesicles. Here and there was a pustule. On wrist and back of right hand the skin had become excoriated, and there was quite profuse discharge and some crusting. Hands doubtless made worse from use of strong soap. There was oozing from skin of left auditory meatus and slight crusting. This case was a clear example of the papulo-vesicular type of eczema.

The symptoms were suggestive of local irritation, as in what is generally known as “poisoning” from “poison ivy” (*rhus toxicodendron*) or the poison from sumach, but there was no history of exposure to any external irritation of this character. Patient was four months pregnant, fifth child, and there was a question as to the influence of this condition.

R. Acid salicyl., ʒii.  
Zinci. oxid.,  
Amyli, aa ʒi.  
Ungt. simp., ad. ʒviii.

M.

Sig.—Keep diseased surface covered with this and protect hands with rubber gloves.

There was steady improvement, and the patient was practically well in twelve days, after which I did not see her.

A second case, general in localization, was that of an old lady, aged eighty-five. Type squamous, chronic; duration five months. Began on body and about axillæ as "weeping" and crusting patches, soon becoming thickened and very scaly. When seen, on the back of the neck, the axillæ and adjacent skin, various parts of the body, arms, legs and about pudenda and buttocks were thickened patches of glazed appearance, upon which large, thin scales formed. Here and there variously sized fissures were seen. General skin atrophic (senile) and itchy.

R. Picis liq.,  $\mathfrak{z}\text{iv}$ .  
Camphoræ,  $\mathfrak{z}\text{ii}$ .  
Ungt. diachyli,  $\mathfrak{z}\text{iv}$ .

M.

Sig.—Test on one patch, if acts well apply to all, keeping on constantly.

When the ointment was, finally, properly applied there was marked improvement. After three weeks—

R. Cascar. sag. F.E.,  $\mathfrak{z}\text{ss}$ .  
Tinct. nucis. vom.,  $\mathfrak{z}\text{i}$ .  
Tinct. cinchon. comp.,  $\mathfrak{z}\text{ii}$ .  
Aquæ, ad.  $\mathfrak{z}\text{iv}$ .

M.

Teaspoonful after meals was given for "tonic" effect and to keep bowels open.

R. Saponis viridis,  $\mathfrak{z}\text{ii}$ .  
Sp. vini. rect.,  $\mathfrak{z}\text{i}$ .

M.

was used to "scrub" patches once daily, after which the ointment was reapplied. The pix liquida was decreased one-half, and acid salicylic grs. 10 to the ounce of ointment was added about six weeks from beginning of treatment. Despite the age of the patient and the difficulty of getting the treatment thoroughly applied, the disease became much less troublesome, and so far as I learned, remained so until the patient's death, four months later. A relative says disease first became severe after a course of *royal germateur*.

A curious case of "*trade eczema*" was that of a negro hostler, aged twenty-two. Duration four days. On, and between fingers and forearms, on rest of skin surface slightly, numerous acuminate, pin-head sized papules. "Special arrangement" or localization, not present. Some of the papules pierced by a hair. No vesicles visible even with a lens. Only sensation was that of slight pricking when warm. Allowed the dust from the horses curried to remain on skin, though he said he washed his hands and wrists. This dust was probably partly composed of dried excrement, from the stalls, and irritated the skin. No evidence of syphilis or scabies.

Ordered free use of soap and water, a nightly bath and the application of the "pigment" of *pitch, ether and alcohol*. Perhaps so much soap and water was against his scruples, as he did not return.

The case of erythematous eczema in the child, described in Article I., is an example of general eczema of this type, viz.: erythematous. Hence, we have described three types of general eczema, the erythematous, the papulo-vesicular, and the chronic squamous. As a general rule an eczema does not remain of a distinct type throughout its course, but may represent different types at different times or belong to the "mixed" type. While acute and active, the disease must receive soothing, a stringent and protective treatment; when chronic and indolent, "stimulating" treatment is, as a rule, indicated, but there should be no effort at destruction of a chronic eczema by *caustics*.

A case of eczema may last, under proper treatment, from three weeks to three months, or longer, but should always be considered curable with proper treatment and the ability to regulate the general health.

(*Seborrhoeic Eczema next article.*)

16½ Whitehall St.

## Society Reports.

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### GYNECOLOGICAL AND OBSTETRICAL SOCIETY OF BALTIMORE.

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#### JANUARY MEETING.

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■ The President, Dr. Henry M. Wilson, in the chair.

Dr. W. P. Chunn related an instance of

#### APPARENT GROWTH OF THE PLACENTA AFTER LABOR.

The patient was twenty-eight years old, and had been married five years. She had had no children at full term, but had had three miscarriages. The first and second miscarriage occurred at about the fourth month of gestation. The last miscarriage occurred about May 10th, 1890. She had missed one period, and believed herself to be about six weeks pregnant. On the 10th of May she began to have bearing down pains and hemorrhage with the expulsion of blood clots, lasting some three or four days. Then the pains subsided, the hemorrhage ceased and I regarded the uterus as empty. On the 12th of June, however, she was again seized with violent pains, and during the night was delivered of a placental mass larger than a man's fist, which I saw the next morning; the patient, as well as myself, was surprised. The foetus was searched for but no sign of it found.

Dr. Thomas A. Ashby: I have seen a somewhat similar case. The patient began to have hemorrhages about the sixth week of gestation. She was not under my care at that time, but I was called in four weeks subsequently, and she was then in the act of throwing off the foetus. At the time of its removal the foetus was apparently at the sixth or seventh week of gestation and partly decomposed. The placenta was not affected by

decomposition. Before I saw her she had been going around bleeding from this cause, and was not aware that she was about to abort. She had had five miscarriages between the sixth and eighth week in twenty-eight months, so she stated.

Dr. G. W. Miltenberger: I have known the whole ovum to be retained for months after the death of the foetus. In a recent case the contents of the uterus were not thrown off till full term, though the foetus was dead at the third month. I cannot understand the growth of the placenta *in utero* after the death of the child; but I can conceive the growth of the placenta outside of the uterus on account of the peculiar relations of the blood vessels.

Dr. L. E. Neale: I think it is very unfortunate that the specimen is not presented. The placenta is not developed in the sixth week of pregnancy.

The conditions in the extra-uterine pregnancy are very different from those in the intra-uterine pregnancy, and what is true of one regarding placental development is not true of the other. I see nothing in the history of the case opposed to the belief that it was a very ordinary case of abortion (not miscarriage) with escape of the embryo and more or less complete retention of the sac, chiefly chorion, that might have been removed by the curette long before it was ultimately expelled.

Dr. L. E. Neale read a paper upon "The Indications for Cæsarean Section."

This paper is intended to stimulate interest in and discussion of the subject of Cæsarean section *vs.* craniotomy on the living child, upon which subject a series of papers will be presented by the Society. It refers particularly to the indications for the section, and is a plea for this operation.

If it serves to arouse interest in examining pelvis or increase hesitancy in destroying children, the labor is not in vain.

Craniotomy upon the living foetus is believed justifiable, but only as a dire necessity, not as an elective procedure, and should not be resorted to where there is a reasonable probability of success by the section, and the uncoerced consent of the mother can be obtained.

No man is compelled to do craniotomy upon the living foetus solely upon the choice of the patient or her friends.

In answer to the question, "What would you do if the patient were your wife, your sister, or a near relative?" he believed practically this must be a matter for each man's conscience, over which no dogmatic rule of science can or should have sway.

If seen early enough the induction of premature labor at the 32d to 34th week, by the method of Krause, was a very strong antagonist to craniotomy upon the living foetus. The range for this operation should not extend to a *conjugata vera* below  $2\frac{3}{4}$  inches (7 cm.), or to one above  $2\frac{1}{2}$  inches (8.75).

The indications for the conservative section included all insurmountable obstructions to the delivery of the living and viable child *per vias naturales*.

They include tumors, pelvic exudations, hypertrophic elongation of the cervix, cicatrices, stenoses, tetanus uteri falciform, uterine contractions, etc. He believed general opinion placed the limit for the absolute indication at a *conjugata vera* of  $1\frac{1}{2}$  inches, or 3.75 cm., and the relative indications extended from that point up to an undetermined *conjugata vera* measurement, and included many other conditions besides pelvic contractions. Other things being favorable, a  $2\frac{1}{2}$  inch or 6.25 cm. *conjugata vera* (Harris), 3 inch-7.5 cm. *conjugata vera* (Lusk), called for section rather than craniotomy, but he warned against relying entirely upon pelvimetry in the relative indication.

In contracted pelves he preferred version to forceps when both were practicable. He insisted on pelvimetry and briefly outlined the methods. He believed it was chiefly by this means we could determine the indications for the section.

A *conjugata vera* of 3 inches (7.5 cm.) was generally admitted to be the least through which a living child of normal proportions could pass, and, as Lusk maintained, if other diameters were lessened or the contraction was not limited to the brim, it might require a *conjugata vera* of  $3\frac{1}{2}$  inches, 8 cm. or more.

No hard and fast line could be given; each case must be judged alone. The relative size of the head, its resistance, the past history, the uncoerced consent, the general condition and

surroundings of the patient, etc., were all important factors in the relative indication.

The life of the child was not "purely impersonal and scientific," but eminently personal and practical, and he believed the mother should run a reasonable risk in its interest. The life-saving of craniotomy could never be as great as that of Cæsarean section for it started with a necessary mortality of 50 per cent., or half the lives at stake. But aside from all argument and comparative statistics, the section was decidedly restricting craniotomy. All deprecate the repeated performance of craniotomy on the same woman. He accepted Carl Brann's rules for the relative indication.

Craniotomy was safer for the mother than section; but piecemeal extraction was equally, if not more dangerous.—Ex. 92, *conjugata vera*  $2\frac{1}{2}$  inches, 6.28 cm. or less.

If conservative delivery, *per vias naturales*, had been attempted and failed, this was a strong point in favor of craniotomy and against the section under these increased dangers.

He strongly deprecated conservative tampering and then resorting to the section; many lives had been thus sacrificed. If we desired success, we must make the section an elective operation and not a procedure of dire necessity.

Dr. Miltenberger: With regard to the paper of Dr. Neale, confined as it is to the indications for the Cæsarean section, there is nothing which I would controvert. Under the absolute or positive indications, as laid down, there can be no question.

The confusion and discrepancy of opinion have arisen from want of definiteness and clearness as to the relative indications.

If we take the statistics of craniotomy generally, including all cases, we get no positive resulting data to guide us. Where the pelvis is so contracted as to necessitate the piecemeal extraction of the fœtus, it is recognized undoubtedly as the most serious of obstetric operations, and more dangerous than Cæsarean section. Where, on the other hand, craniotomy alone is required, the operation is simple and the danger to the mother in proper hands, should not be greater than from the application of the forceps. In my individual experience on my own patients, I have



been obliged to resort to craniotomy but twice in fifty years, and in these, as well as in those in consultation practice, the mothers have all recovered.

Now, it is in just this latter class that the doubt arises.

The smallest conjugata vera diameter through which a living child has been expelled is 3 inches, or, as has been claimed,  $2\frac{3}{4}$  inches; but with this we cannot expect to save the child through the natural passages.

But whether with this or a little more available space, we must recognize the prime and absolute importance, as the doctor states, of pelvimetry; and to its thorough, practical study and application must we mainly look for increased certainty. Especially does this hold as to the internal pelvimetry, the best instrument, by far, being the hands of the obstetrice.

Now, while it is true, the measures here of the conjugata vera by the finger may not be perfectly accurate, and we require also to learn the available space in the transverse diameter, yet with care it sufficiently approximates the truth for our purpose. But, on the other hand, as the doctor has said, we cannot accurately determine the size of the child's head, its degree of ossification, etc. It is true by bimanual examination we can approximate the truth, but not exactly obtain it. I have known an accomplished accoucheur persist for a length of time in the use of forceps before he recognized that he was dealing with a hydrocephalic head. Thus both the factors have elements of uncertainty.

It is just in this class of cases that the doubt and uncertainty arises.

When the practical obstetrice meets with a case of dystocia from this cause, by internal measurement he satisfies himself, as far as possible, he has 3 inches of available space in the conjugata vera, or even above this, without a full knowledge of the size of the fetal head, he naturally applies the forceps, or proceeds to turn, and not improperly, but if he fails, he has already violated the first fundamental law in cæsareotomy, to resort at first to the knife, without any previous manipulation; if such manipulation has been at all prolonged, the choice is not between

craniotomy and Cæsarean section, but between craniotomy and a Porro.

Fortunately pelves contracted to this extent are rare in this country, particularly in the higher walks of life.

The operation of cæsareotomy is in itself sufficiently simple, and the modern section is undoubtedly one of the greatest advances in modern obstetrics, while its success constitutes a brilliant epoch in our recent history. In the hands of those skilled in its technique, and taught and trained by experience, there is every reason to trust and believe that the modern Sænger will extend still farther its successes, and that as an operator gains tact and knowledge with every case with which he deals, and as a part of his success most depends upon his absolute command of his patient and her surroundings, it is most likely the old picture will be reversed, and with our septic and anti-septic precautions, hospitals will offer a smaller rate of mortality than private practice.

Fully realizing, as I do, the success of the modern Sænger, and the lessened mortality rate which has been achieved, yes, we know that no abdominal section is entirely free from danger, and, as I said, in these cases of relative indications, they may be claimed to be almost, if not entirely, void of peril with craniotomy.

I do not hesitate to declare that I should prefer, on my own wife, as the safer for her, craniotomy to Cæsarean section in such a case, and am therefore bound to extend to others, my patients, the golden rule: "Do unto others, as I would they should do unto me."

I am, therefore, forced to the opinion that Cæsarean section will not completely supplant the old operation, and there still remains a field, although materially limited, for craniotomy on the living child.

Dr. J. Whittridge Williams: I am sure that all of us are greatly indebted to Dr. Neale for the very clear manner in which he has set forth the indication for the operation, and I almost entirely agree with him.

The absolute indication I would place at 5.5½ cm. or 3 inches, and the upper limit for the relative indication at 7½ cm. or 3

inches. Within these limits, unless the child be abnormally small, there should be no question as to the use of forceps; and the question to be decided is whether craniotomy or Cæsarean section should be done.

Theoretically, I would choose the section in all cases that appeared favorable; but practically, I might waive my theory in the case of a primipara who had not been examined previous to labor. For in that case it might appear very hard to submit a young woman to such a risk without any previous intimation of her danger.

But if I performed craniotomy under these circumstances I would warn her that in becoming pregnant again she would take the responsibility of the child's life upon herself, and that I would refuse to perforate in subsequent pregnancies.

The mortality of the operation need not dismay, for Munchmeyer has lately reported the latest statistics of Leopold, in which he reports 28 Sænger operations with the loss of three mothers and one child, and 7 Porro operations with no maternal deaths. □

Dr. B. B. Browne: I had a case recently upon which I did Cæsarean section. The woman was 27 years of age. She had had one child. Her labor was two years ago, when she had convulsions and a craniotomy was done. As a result of injury received at this time, the vagina and uterus sloughed and there was complete atresia of the vagina. This atresia was afterward opened up, and she became pregnant.

The vagina was contracted by cicatricial bands, and an opening could be felt in the side of the cervix, but to the left of the opening was a cup-shaped cavity which might have been the old cervix.

She was not sure of the time of impregnation. She was swollen and her urine solidified with albumen upon heating. Labor pains began December 20 and continued for one or two days, but there was no dilatation. She came to the hospital December 22. She had severe uterine contractions that day, and came for the purpose of having Cæsarean section done. But next day the pain had all gone. The night of January 1st the water broke and severe pains began. The cicatricial bands about

the cervix were cut and Elliot's forceps were introduced. Both blades of Tarnier's forceps could not be gotten on. After several efforts I concluded that she could not be delivered in that way. In the morning the foetal heart was distinct; in the afternoon it was feeble.

The section was made without difficulty. The placenta was attached in front. The child could not be resuscitated. The placenta was readily detached, and the uterus was cleaned out and closed by the Sænger method.

The operation was done on Friday and the patient did well until the following Tuesday, when she sank rapidly and died in a few hours.

The woman had grave kidney disease and had little chance of recovery on that account.

In this case several things are to be considered.

1st. The woman was perfectly willing for the operation.

2d. Her life, from the condition of her kidneys, was not insurable, and the child had a good chance of living.

3d. She had much difficulty in the former craniotomy and barely escaped with her life.

Dr. Ashby: I have had the good fortune to witness two Caesarean sections—one, the case of Dr. J. G. Joy, of this city, several years ago, and the recent case reported by Dr. Browne. I was impressed with the ease with which the operation can be done. Its mechanical execution is certainly much less difficult than that necessitated by many intra-abdominal operations. Hemorrhage is easily controlled, and the closure of the uterine wound is not a difficult undertaking.

In the case of Dr. Joy, the mother made a prompt recovery, and the child perished simply because of the unavoidable delay which was experienced before an attempt at its removal was made. Its death had, in my opinion, no relation to the operation, but to causes which antedated the section. I am convinced, in the case of Dr. Browne, the child could have been saved had no other method of delivery been attempted. The section, I think, bore no relation to its death.

In this case the operation was skillfully done, and I am inclined

to believe that the mother's death should be assigned chiefly to her kidney complications. She was a bad subject, but bore the section well.

My opinion of the Cæsarean section is altogether favorable. It has come to stay, and with an improved technique and larger experience will be approached with less hesitation.

The operation of the future will be approached without delay and before other methods of delivery have been employed.

The important indication for the operation rests upon careful pelvic measurements and determination, in advance of any obstetric interference, of the improbability of delivery by version or forceps. If this is done a section will be approached under its most favorable aspects, and its results will be far more satisfactory.

I agree with Dr. Miltenberger in that personally I would prefer craniotomy, if the patient were a member of my own family; but upon scientific grounds, I would not hesitate to operate did my patient and her friends elect this procedure, having satisfied my own mind that a living child could not be born in any other way.

I think it unfortunate that the physician in charge of these cases should not have the moral support of the public and profession in the selection of the section in advance of attempts at other methods of delivery. Out of deference to a sentiment he often feels forced to use the forceps and version where his own judgment was in favor of the section.

Valuable time is thus lost and the lives of both mother and child endangered, if not sacrificed.

Dr. Neale: As no points were raised against the paper, I have nothing to say in its defence. I did examine Dr. Browne's case, and told him, in my opinion, it was no case for the section.

The chief obstruction was in the soft parts; that of the pelvis was very slight, if any. I thought it possible to deliver the child alive, *per vias naturales*, but was sure it could be readily extracted after craniotomy. Owing to the kidney complication, the mother was in a most unfavorable condition for the section, and

for that matter the child also, therefore I advised against the operation.

However, after once beginning a conservative delivery, *per vias naturales*, which was persisted in too long (30 minutes), I certainly never should have resorted to the section in that case, with both child and mother in the then most unfavorable condition, but would have delivered at once by craniotomy.

I totally and emphatically differ from Dr. Ashby that any conscientious obstetrician should ever be forced to resort to craniotomy by the moral suasion of the patient or her friends. Such teaching would be extremely pernicious.

The sentimental question of what one should do if the patient were his wife, etc., is a matter of individual conscience and not open to scientific discussion before a medical society.

I again request the fellows not to let this matter rest where we leave it to-night.

I wish to emphasize the fact that I have purposely avoided any reference to the religious aspects of this question, as I do not believe this point is open for scientific discussion before a medical society.

WILLIAM T. GARDNER, Secretary.

41 S. Hanover St.

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## THE PHILADELPHIA ELECTRO-THERAPEUTIC SOCIETY.

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WM. H. WALLING, M. D., SECRETARY.

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The February meeting of this society was held at 36 North Nineteenth street, February 8. President G. Betton Massey, M. D., in the Chair. The minutes of the last meeting having been read and approved, and the Treasurer's report having been received and accepted, the society went into the election of officers for the ensuing year, with the following result:

President, Matthew W. Grier, M. D. ; Vice-Presidents, I. P.

Willits, M. D. ; and Horatio R. Bigelow, M. D. ; Secretary and Treasurer, Wm. H. Walling, M. D. ; Executive Council, Drs. G. Betton Massey, J. J. Taylor, and W. H. Walling.

DR. MASSEY then read the following paper :

**ELECTRO-PUNCTURE OF A CYSTIC GOITRE ; DISAPPEARANCE OF BOTH CYST AND GOITRE.**

A maiden lady, aged forty-one years, was brought to me by Dr. Emily W. Wyeth, October 1, 1889, with an irregularly shaped goitre, about the size of a small orange. The left lobe was much the larger and was the seat of a monocyst of considerable proportions which had increased very much during the last year, the growth having been noticed about seventeen years. The circumference of the neck at this point was sixteen and three-eighths inches. Treatment was begun by a negative puncture of the cyst with a solid needle, 35 milliamperes being used for fifteen minutes. This was followed by a considerable oozing of a straw-colored liquid. Four days later the cyst was evacuated of its contents, measuring an ounce and a half, and 40 ma. negative applied to the cyst walls for ten minutes, by means of the canula acting as an electrode, the latter being insulated as far as the cavity. This procedure was repeated five times subsequently, with current strengths rising to 106 ma., the cavity being permitted to refill after each puncture. Careful measurements showed that the cyst was refilling more slowly after each application, but on December 9 it was decided by Dr. Wyeth and myself to make a free opening and apply the positive pole, by means of a gold bulb electrode, to all sides of the cavity at stated intervals, maintaining free drainage in the meantime. This procedure was required but twice, with currents of 100 and of 50 ma., the drainage tube, which was most assiduously looked after by Dr. Wyeth, being gradually shortened and removed on the seventh day. During this time the patient suffered a slight rise of temperature, due to a temporary obstruction of the discharge by accidental removal of the tube. By February 21, nothing remained of the growth but a cicatricial lump about the size of a peach stone, and two months later this had also disappeared without further treatment.

*Discussion.*—DR. GREER has never treated the cystic variety, but has used outward applications on true goitre, with currents of not over twenty-five ma. He used tin electrodes covered with muslin, placing the positive pole on the inferior cervical ganglion, and two negative plates upon the tumor, one on each side. The sittings lasted for five minutes each, being repeated three times a week, for from two to three months. Some preparation of the iodides was also used. Favorable results were obtained in about fifty per cent. of the cases.

DR. PETERSON spoke of a case in which the fluid extract of ergot was used, with good effect, being applied to the tumor upon the positive pole.

DR. BIGELOW : There is a canton in Switzerland in which you cannot walk out without meeting a goitre. The disease is not confined to those who drink the waters, neither to those who carry heavy burdens on their heads.

DR. BIGELOW could not see why the same treatment should not be followed in a fibroid in the neck, as well as in any other part of the body.

In a cystic tumor the action of the current was: 1, Electrolysis; 2, the arresting of the secretion; and 3, to compel absorption. He also thought that constriction should act well in such cases. Dr. Neggaroth uses the faradic current in overcoming ovarian cysts. He applies the negative pole to the ovaries, per vagina, and the positive on the abdomen, using swelling currents for an hour at a sitting, obtaining good results in six weeks. It must be the heavy voltage that acts so favorably, and if in one case, why not in another?

DR. GREER had used faradism in goitre, but abandoned it on account of its unpleasant effects.

DR. WALLING: Dr. Massey says that he emptied the cyst before applying the galvanic current. We must be guided by experience as well as by theory. Why was the positive used? Was not the negative pole the one indicated? In the treatment of hydrocele, Dr. Walling does not drain the sac, unless it is extremely distended, and then but little. Used the negative needle



in the tumor, and the positive on the thigh, with a current strength of fifteen ma. for fifteen or twenty minutes. He had excellent results in such cases. Scarcely any inflammation followed, and the contents of the cysts were rapidly absorbed, with obliteration of the sacs.

He had used the strong faradic current, but saw no benefit from it, although it caused strong contractions of the muscles. Why not treat other cysts in the same way? You cannot reach all parts of the surface of the sac, after emptying it, while some parts would be unduly acted upon, tending to set up too much inflammation. What better electrolytic than the fluid in the sac, thus reaching every portion alike.

DR. MASSEY said he was disposed to regard the faradic current as of no value in cystic tumors; but in one case, where a cyst developed in a fibroid, he used a strong faradic current with great advantage. He regarded aseptic aspiration, followed by electrolytic puncture, as the best procedure in cystic conditions.

Adjourned.

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### WHAT IS ORTHOPÆDIC SURGERY?

AT the session of the Orthopædic Section of the Tenth International Medical Congress, at Berlin, Dr. Newton M. Shaffer, of New York, read a paper in which he defined orthopædic surgery as "that department of surgery which includes the prevention, the mechanical treatment, and the operative treatment of chronic or progressive deformities, for the proper treatment of which special forms of apparatus or special mechanical dressings are necessary." While holding that the orthopædic surgeon should be a good general surgeon, yet, he says, in the field of mechanico therapy he will find abundant opportunity for the exercise of his talents without trenching on the ground of operative surgery. The wide and important field of mechanico-therapy is too often ignored in the college curriculum; and the length of treatment in these cases prevents students from taking the same interest in such patients as they take in those treated at the medical and surgical clinics. The writer makes a strong plea for the separation of the specialty from general surgery. —*The New York Medical Journal*, February 21, 1891.

## Book Reviews.

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**THE SCIENCE AND ART OF OBSTETRICS.** By Theophilus Parvin, M. D., LL. D., Professor of obstetrics and diseases of women and children in Jefferson Medical College, Philadelphia. Second edition revised and enlarged: Lea Bros & Co.

The above is a valuable contribution to the practice of modern midwifery, easily ranking with those other classics on the obstetric art, the works of Playfair and Leishman. There is probably no one better qualified to write and speak on this subject than Dr. Parvin, and he has done so in a masterly way. While not departing too much from reliable landmarks the author has brought his book thoroughly abreast with the time. In this regard we refer specifically to the sections of Ectopic Pregnancy, and antiseptics in Labor.

If we were to find fault at all it would be with the arrangement of subjects. But, on the whole, excellent.

L. B. G.

**AN ENCYCLOPÆDIC MEDICAL DICTIONARY** Vol. II., edited by FRANK P. FOSTER, editor of the *New York Medical Journal*. D. Appleton & Co., New York.

We receive with pleasure the second volume of this great work which well sustains the ambitious purpose of the editor and his able assistants. The book-reviewer is given no opportunity for unfavorable criticism. Of making dictionaries nowadays there seems to be no end, but this immense work for a great many years will be our supreme authority on "medicine and the collateral sciences."

The publishers' task is done faultlessly.

L. B. G.

## Editorial.

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### RECENT GRADUATES.

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Within the next few weeks hundreds of young M. Ds. will be graduated from the numerous medical colleges in this country—many of them after having attended only two courses of lectures of five or six months each, with little or no preliminary instruction. Some of them without ever having stopped to consider the grave responsibilities which they are so lightly assuming. Of these latter many will soon drop by the wayside. They find themselves in an uncongenial atmosphere, where they cannot grow and develop, so they seek other and more pleasing occupations.

But there are others, and they are greatly in the majority, who realize the high calling of the profession, and are willing to work for the good of humanity and the development of science. They do not expect to amass wealth, but what is far higher and better, they expect to decrease the sum total of suffering and sorrow. They are prepared for lives of self-denial and devotion to duty, though beset by temptations on every hand—temptations far more powerful and insidious than any other profession is subjected to. The laity know little of medicines or of their effects on the animal economy, and the temptation to cover up inexcusable mistakes is great. The physician is brought into the most intimate relations with his patients, and it should be ever uppermost in his mind that the obligation to protect their morals is no less solemn and binding than is the obligation to minister to their physical infirmities.

The physician who becomes too much engrossed with the mere money-making side of his profession, who devotes a large proportion of his best thought and energies to making judicious investments, will soon find that his patients will conclude that he cares more for money than he does for medicine. The men who realize the highest and best that the profession offers them must ever keep paramount the good of humanity and the development of the healing art. They may not accumulate money; they may not become famous; their lives may often seem to them to be failures, but the world will be better for their having lived in it; They who accomplish less than this are failures, no matter how much of apparent success may have been attained.

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### ANNOUNCEMENT.

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With this issue of the JOURNAL Dr. Luther B. Grandy, who has purchased an interest, will become actively connected with its editorial management. Dr. Grandy is one of the brainiest and most competent young men in the profession. We feel sure the accession of Dr. Grandy will prove of great benefit to the JOURNAL.

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### OUR SYMPATHY.

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Our valued New York correspondent, Dr. William L. Russell, writes that he was unable to furnish his usual letter, owing to the death of his little boy.

The JOURNAL extends its most sincere sympathy to the Doctor and his wife in their great sorrow, and hopes Time will kindly heal the wound of so severe a loss until they may become somewhat resigned to their affliction.

ITEMS.

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LATE DEVELOPMENT OF HYDROPHOBIA.—W. G. Spencer, M. S., reports (*British Medical Journal*, Feb. 7, 1891) the longest authentic period of time elapsing between the infliction of a bite by a rabid animal and the development of hydrophobia, viz.: two years and four months.

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Eight patients are being treated in the Post-Graduate Hospital by Koch's lymph. Three of them are cases of lupus; four are cases of phthisis pulmonalis, and one laryngeal tuberculosis. The inoculations are in charge of Dr. W. C. Bailey, who was for a long time a student in Koch's laboratory, assisted by the director of the laboratory, Dr. J. H. Linsley.

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We learn from the *Medical Record* that a great deal of medical legislation is being done out in California just now.

It is proposed to appoint a State Veterinary Surgeon. Also to regulate the practice of pharmacy and the sale of poisons; to establish a State board of funeral directors; to regulate the practice of veterinary medicines; to forbid the sale of cigarettes to boys; to appropriate \$80,000 to the medical department of the University of San Francisco. All of which is probably well enough; but we modestly suggest to the regulating law makers the appointment of a Board of Medical Examiners. As a well "regulated" State, California would then be a distinguished success.

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In a late *Medical Record* (Feb. 21) Dr. A. M. Phelps, of New York, describes in detail his recent attempt at grafting the bone of a dog to the tibia of a boy, for the treatment of ununited fracture.

The operation consisted in freshening the ends of the bones and inserting between them about an inch of the dog's radius, the nutrient artery supplying the latter being preserved.

This operation has been considerably discussed in the secular press, and, as usual, there was not lacking some over-humane in-

dividuals who looked upon the procedure only as a cruel experiment upon a dog.

So far as affording relief to the patient is concerned, the operation was not a success. Sufficient time (only eleven days) was not given for bony union to occur; but nature was evidently doing her best. On the whole, the result was encouraging, and we hope subsequent trials will be more successful.

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THE MISSISSIPPI VALLEY MEDICAL ASSOCIATION will hold its seventeenth annual session at St. Louis, Wednesday, Thursday and Friday, October 14, 15 and 16, 1891. A large attendance, a valuable programme and a good time are expected. The members of the medical profession are respectfully invited to attend.

C. H. HUGHES, M. D., President,  
500 N. Jefferson Ave., St. Louis.

E. S. MCKEE, M. D., Secretary,  
57 West Seventh St., Cincinnati.

I. N. LOVE, M. D., Chair. Com. of Ar.,  
301 N. Grand Avenue, St. Louis.

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### GOLD AND MANGANESE IN TUBERCULOSIS.

On Tuesday evening last, before the Section in General Medicine of the New York Academy of Medicine, Dr. J. B. White, physician to Charity Hospital, read a paper on the therapeutic value of gold and manganese when subcutaneously administered to patients suffering from pulmonary or other forms of tuberculosis. He makes use of a solution each drop of which was said to represent one fiftieth of a grain of some salt or salts of the metals. For injection one or two drops of this are added to five or ten minims of a one per cent. solution of carbolic acid. The administration of the remedy is followed by a pronounced reaction in its general characteristics similar to that produced by Koch's liquid. Dr. White narrated the histories of a number of pulmonary cases treated by him at Charity Hospital, from which it might be deduced that the expectoration has been remarkably lessened in quantity, in one instance from fourteen

ounces to two in twenty-four hours. An increase of appetite had been observed in all the cases. The improvement in respiration had not been so immediately apparent as the other evidences of general amelioration, but the patients had, nevertheless, all been more or less relieved in their breathing. One of the most encouraging results had been the decided effect upon the functions of nutrition, as shown by the increase of weight. In one instance this had been as much as seven or eight pounds in a few weeks. Without exception, the patients had expressed themselves as feeling better under the treatment. The speaker, who was corroborated by several colleagues who had followed his experiments, said that he did not wish to be understood as urging any specific virtue for this remedy, but thought that further trial was likely to demonstrate its value as an adjuvant to the general treatment of tuberculous cases. —*The New York Medical Journal*, February 21, 1891.

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#### REMOVAL OF A PORTION OF THE LIVER WITH THE ELASTIC LIGATURE.

At a meeting of the Académie de Médecine of Paris on January 7th, M. Simon Duplay reported on a case in which M. Terrillon had removed by means of an elastic tube a portion of the liver containing numerous hydatid cysts of small size. The patient (a woman, aged 53) had for six years suffered from frequently repeated attacks of sharp pain in the right side, and had noticed for some time a slowly increasing tumor in the region of the liver. On August 1st, 1889, laparotomy was performed by an incision about six inches in length parallel to the lower border of the false ribs on the right side. On subsequent enlargement of this wound and free exposure of the liver, a portion of the right lobe, about the size of two fists put together, was found to be studded with numerous small cysts. There was a very sharp line of demarcation between the healthy and diseased portions of the hepatic tissue. After an unsuccessful attempt to remove the diseased portion of liver by the thermo-cautery, the use of which

was followed by much bleeding, M. Terrillon constricted the base of the growth by a rubber tube. The strangulated portion of the liver, which was fixed outside the wound in the abdominal wall, gradually mortified, and, after the removal of the ligature on the seventh day, was cut away. The large open surface that was left soon healed, and ultimately the patient made a complete recovery. In his remarks on this case, M. Duplay stated that several instances had been recorded of removal of a more or less considerable portion of the liver, such treatment having been practised in accordance with one or the other of two very different indications. The surgeon has had in some cases to deal with a hernia of this organ through a penetrating wound of the abdominal wall, and to remove by the knife the protruded portion; and in other cases removal has been performed after laparotomy, with the object of extirpating a hepatic tumor. Of the former class of cases, about ten instances have been recorded, in the majority of which, notwithstanding an absence of antiseptic precautions, the patients recovered. Very few cases, however, probably not more than three, have been published in which removal of a new growth had been attempted. In each of these the operation was attended by alarming and, indeed, in one instance, fatal hemorrhage. As an ordinary and non-elastic ligature usually tears through the friable hepatic tissue, the application of an elastic ligature, as suggested and practised by M. Terrillon, constitutes, M. Duplay holds, a decided progress in the *technique* of resection of the liver. This method of hæmostasis is applicable not only to pedunculated but also to sessile tumors, in which later the elastic ligature fulfils a double object: one of producing, through constriction of the tissue of the liver, a kind of artificial pedicle, which permits exact circumscription of the diseased part, and facilitates its subsequent removal by the knife; the other of very effectually securing the patient against the risks of hemorrhage.—*Supplement to the British Medical Journal, February 7, 1891.*



## ADULTERATION OF DRUGS.

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We call attention to the following circular letter:

GEORGIA STATE BOARD PHARMACY,  
OFFICE OF SECRETARY,  
LAGRANGE, GA., March, 1891. }

H. R. SLACK, Analytical Chemist. MEMBERS: John W. Goodwyn, Chairman, Macon; H. R. Slack, Secretary, LaGrange; S. C. Durban, Augusta; Harry Sharp, Atlanta; F. Joerger, Brunswick.

The Georgia State Board of Pharmacy has issued the following letter to the druggists:

DEAR SIR—Your attention is respectfully called to the law against adulteration, which was passed by the Legislature, in 1889, but has not been enforced because of lack of funds.

### ADULTERATION LAW.

SEC. 9. No person shall within this State manufacture for sale, offer for sale, or sell any drug, medicine, chemical or pharmaceutical preparation which is adulterated. A drug, medicine, chemical or pharmaceutical preparation shall be deemed to be adulterated: (1) If, when sold under or by a name recognized in the U. S. Pharmacopœia, it differs from the standard in strength, quality or purity laid down therein. (2) If, when sold under or by a name not recognized in the U. S. Pharmacopœia, but which is found in some other standard work, it differs materially from the standard of strength, quality or purity laid down in such work. (3) If its strength, quality or purity falls belowed the professed standard.

The last Legislature made the necessary appropriation to enable the Board to execute the law.

The Board intends to buy up samples of drugs from different sections of the State and have them analyzed. If analyses show goods to be adulterated, the parties selling them will be prosecuted.

The fine is \$100 and the expense of analysis to be added.

The law makes you responsible, not only for the goods you make yourself, but also all that you sell manufactured by others;

you therefore see the necessity of making tinctures, etc., from full strength goods, and buying drugs and chemicals of strictly reliable firms.

Wholesale druggists are especially warned against making Grocerymen's Laudanum. You can make half-strength goods, but you must so label them or suffer the consequences.

Hoping you will give this your attention and help us in our efforts to elevate the standard of pharmacy in our State, we are,

Yours truly,

JOHN W. GOODWYN, Chairman.

H. R. SLACK, Secretary.

P. S.—The next meeting of the Board will be in Augusta, May 11th. The Georgia Pharmaceutical Association meets there the next day. Hope you will attend.

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## CONSTITUTION—THE UNITED STATES MEDICAL PRACTITIONERS' PROTECTIVE ALLIANCE.

FOUNDER: Dr. J. H. DeWolf, Baltimore, Md.; President, Dr. W. H. Crim, Baltimore, Md.; Vice-President, Dr. W. V. Wilson, West Haven, Conn.; Secretary, Dr. J. F. Davidson, Glendola, N. J.; Treasurer, Dr. R. B. Elderdice, McKnightstown, Pa.

### ARTICLE I.

This Society shall be known as the United States Medical Practitioners' Protective Alliance.

### ARTICLE II.

The object of this Association shall be to maintain organized co-operation amongst the practicing physicians, who are legally qualified to practice in their respective States, and in good standing in the profession; for the purpose of protecting medical practitioners from the abuse of dispensaries that treat many who are well able to pay; from the unjust competition caused by short term, quick graduating, and inferior Medical Colleges. To endeavor to promote the passage of just and equitable laws, regulating the practice of medicine in all the States, so that the license to practice issued in any one State shall be valid in any

other State; and to devise means to enhance our financial condition (and thereby our usefulness) in every honorable way, and to derive the incalculable benefits that only can be obtained by combination and unity of action.

#### ARTICLE III.

The members of this Association shall exercise toward each other, toward all physicians and toward all mankind that courtesy and just dealing to which every one in his legitimate sphere is entitled, and any departure therefrom shall be deemed unprofessional, undignified and unworthy the honorable practitioner. It shall also be regarded as unbecoming to engage in any form of advertising or practice which shall tend to lower the physician in the esteem of the community or reflect discredit upon his professional associates.

#### ARTICLE IV.

The officers of this Association shall consist of a President, Vice-President, Treasurer and Secretary, who shall be elected annually. The seal of this Association must be stamped on all official papers.

#### ARTICLE V.

The fees for membership shall be three (\$3) dollars on admission, and two (\$2) dollars per annum thereafter. Delinquent members to be dropped for non-payment of dues whenever in arrears over two years.

#### ARTICLE VI.

Any member may be officially censured, invited to withdraw, or be expelled from membership for improper conduct or violation of professional comity. But it shall be necessary for a specific charge to be made in writing, with the name of accuser, and a copy to be presented to the accused, or some person acting in his behalf, and another placed in the hands of the President or Secretary one month before the time of holding a regular meeting, when ample opportunity will be given for a trial.

#### ARTICLE VII.

That direct appeals be made by us as a body to the Legislatures of our various States, from time to time, as may be deemed

expedient, to secure the repeal of unjust or obnoxious laws which may be in existence, or the passage of laws that are vital to our success and our welfare as a profession.

## ARTICLE VIII.

That an effort be made to secure a law in each State that will secure the medical practitioner from the many losses he now sustains from those able to pay, but unwilling, and to make the physician's claim in all cases a preferred one, which must be paid before the *pro rata* of an estate, as is now the law in some of the most enlightened countries of Europe.

Those desirous of joining address Dr. J. H. DeWolf, 1600 Franklin street, Baltimore, Md. Please enclose stamp.

PITRES (M.) "De la neurasthenie et l'hystero-neurasthenie traumatique."—*Le Progrès Medical*, December 6th, 1890.

A SEVERE shaking may determine various nervous affections. One patient may present symptoms of true hysteria; another those of ordinary paralysis agitans; a third may suffer from neurasthenia; while a fourth becomes epileptic.

M. Pitres then reviews the symptoms of ordinary spontaneous neurasthenia. He classifies it under the following forms: (1) Cerebral, in which headache (worse by day) is the chief symptom; (2) spinal, with pain in the back, and peculiar sensations in the legs; (3) neuralgic; (4) cardiac, with palpitation and attacks of angina; (5) gastro-intestinal, with dyspepsia and constipation; (6) a group of cases in which the symptoms are referable to the reproductive organs. These divisions are, of course, more or less artificial, for the symptoms rarely belong exclusively to one or other of them. The mental state is nearly always the same—the patient is restless, irritable, and emotional. He reasons about his condition, believes himself suffering from organic disease, and finds pleasure in talking about his ailment. This disease is more common in men between the ages of 20 and 50, and in those of neuropathic tendencies.

Neurasthenia may follow railway accidents. M. Vibert has found in most cases a state of nervous excitement after these accidents, characterized by sleeplessness, headache, tremblings

and excitability. These systems may quickly disappear, but they may last a long time.

The prognosis of traumatic neurasthenia is difficult to give. Recovery is never rapid. In the more favorable cases the disease may last from two to three months, in others, years.

M. Pitres then relates the following cases:—

(1) *Neurasthenia of traumatic origin*.—Man, æt. 25. Fall through fifteen feet. When he regained consciousness, he complained of headache, and vomited. In three weeks' time he got up, and left the hospital shortly after. A little later he was taken with restlessness, and sadness, and headache. Two months after the accident he had constant headache, his gait was unsteady, and although used to scaffolding, he felt uneasy when standing on a chair. He was irritable and morose. This patient recovered.

(2) *Hystero-neurasthenia of traumatic origin*.—Man, æt. 34. Fall through sixty feet. There was some difficulty in articulation shortly after, and sensation on the palate and tongue was diminished. This persisted, and three weeks later there was added tremor of the face muscles, a total right sided hemi-analgesia, and a concentric diminution of the field of vision on both sides. He was sleepless and very irritable. The hemi-analgesia disappeared suddenly, and after hydropathic treatment the cure was complete. The hemi-analgesia, difficulty of articulation, loss of pharyngeal reflex, and concentric diminution of the field of vision were due to hysteria; the mental change, headache, and insomnia, to neurasthenia.

(3) *Symptoms of hysteria, neurasthenia, and Graves's disease*.—Man, æt. 35. Fall through twenty-four feet. Three months afterwards he began to feel fatigue at his work, he could not fix his attention, and walked with difficulty in the dark. He also suffered from palpitation, and his eyeballs became too prominent. He had the globus hystericus. Three months later he had to give up his work. He was depressed, with suicidal tendencies, and suffered from headache. Fourteen months after the accident he was still melancholic, and the headache persisted. His skin and mucous membranes were anæsthetic. Eyeballs prominent, monocular diplopia, both fields of vision concentrically limited. Rapid vibratory tremor in the head and all four extremities. Thyroid gland not enlarged. Urine abundant. He had strange suffocative attacks every night.

It is not difficult to recognize here symptoms usually belonging to three distinct nervous affections, viz.:—hysteria, neurasthenia, and Graves's disease.

The association of hysteria and neurasthenia is common

enough, but it is rare to have exophthalmic gôitre added to them; only one such case would appear to have been published. It is not impossible that complex nervous affections similar to the above are not as uncommon as the number of recorded cases would lead one to suppose.—*The Medical Chronicle, February, 1891.*

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### CAMPHORIC ACID AND TELLURATE OF SODA IN NIGHT SWEATS. TWO NEW ANIDROTIC MEDICAMENTS.

Camphoric acid, which was discovered in 1675 by Lémery, has very recently been made the subject of clinical studies by Leu, in *Centralblatt für Klin. Med.*, and by Dreesmann, in an inaugural thesis. It is obtained by heating camphor with ten times its weight of nitric acid; it presents itself in the form of little scales or colorless needles, which are transparent and bitter to the taste, melting at 70° C., and dissolving freely in alcohol, ether and essential oils, somewhat sparingly in boiling water, and being scarcely at all soluble in cold water.

Leu has remarked that, when camphoric acid is administered to tuberculous subjects who are subject to night sweats, in the dose of thirty grains, it produces a marked anidrotic effect several hours after its absorption; sometimes the suppression of the sweats does not come on till the next day, and the effect of one dose may last several days. The same good results may be obtained from the use of alcoholic lotions of camphoric acid, the lotions being freely applied to parts where the sweating is localized. Leu affirms that no ill effects have ever followed the internal or external use of this remedy. A soporific action sometimes follows the ingestion of a thirty-grain dose.

Camphoric acid was tried in thirteen bad cases of night sweats; in sixty per cent. of these cases the sweats were suppressed, in twenty-two per cent. they were diminished, and in eighteen per cent. only the remedy failed. Dreesmann has found this anidrotic effect of camphoric acid only in tuberculous cases; if the sweats are due to any other cause, the remedy is inefficacious. His experiments have shown that the sweating, which is provoked by pilocarpine, is not influenced by camphoric acid; hence he concludes that this medicament does not act by the intermediation of the central nervous system, but by destroying the soluble products of the tubercle bacillus, which are the direct cause of the profuse sweats symptomatic of the stage of pulmonary ulceration.

Combemale, in the *Bulletin Général de Thérapeutique*, January 15, 1891, has published the results of a series of clinical trials of camphoric acid, and concludes :

(1) That camphoric acid has a certain action on the night sweats of the tuberculous ; it very often arrests them, frequently diminishes them, and is very rarely without effect.

(2) These effects follow doses of thirty grains, once a day, at 7 o'clock P. M.

(3) No disagreeable or harmful after-effect has followed the usage of camphoric acid.

Combemale agrees with Leu as to the necessity of limiting the therapeutic application of the camphoric acid to the night sweats of the tuberculous, and affirms that in his experience it has a very uncertain action in advanced cases of pulmonary phthisis with large cavities. It is in recent cases where the purulent surfaces are small, where the tubercles are still crude, or are just beginning to soften, that it does the most good, and here the remedy is almost infallible in its action.

Another new anidrotic has been announced—tellurate of soda. It is an oxygenated salt of tellurium, and is obtained by heating a mixture of tellurium or its binioxide, with soda or nitrate of soda. It is the normal tellurate ( $\text{Na}_2\text{TeO}_4 + 5\text{H}_2\text{O}$ ) which is employed. This salt is soluble in water and in alcohol, and presents itself after evaporation in the form of a gummy mass or whitish amorphous powder.

Neusser, in *Wiener Klin. Wochenschrift*, 1890, was the first to recommend the employment of tellurate of soda in night sweats. He gave pills of one-third of a grain each, and found one of these pills *per diem* sufficient to restrain the most obstinate night sweats of the phthisical. The ingestion of the remedy is followed by a garlic-smell of the breath, but no injurious effects have been noticed.

Combemale (*loc. cit.*) has made trials of tellurate of soda in phthisical cases ; he has obtained favorable results similar to those recorded by Neusser in nocturnal diaphoresis. He gave small doses, amounting to from half a grain to a grain daily, dissolved in a little julep. He has found that the remedy succeeds in the advanced stages of tuberculosis better than camphoric acid. The tellurate of soda acts equally well in restraining the night sweats of rheumatism, typhoid fever and other prostrating affections. Both remedies are supposed to produce an antiseptic action, destructive of the soluble products of the microbes !—*The Boston Medical and Surgical Journal*, February 19, 1891.

# THE ATLANTA AND MEDICAL SURGICAL JOURNAL.

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## TO CONTRIBUTORS.

Articles for publication must reach this office not later than 15th inst.; and are expected to be published exclusively in this JOURNAL. Extra copies of JOURNAL furnished contributors when requested. Reprints by special arrangement. Publication of an article does not necessarily imply endorsement of the views therein expressed.

MEDICAL AND SURGICAL JOURNAL, Post-office box 431.

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## Original Communications.

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### HOW SHALL WE CURE CROUP?

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By E. F. STARR, M. D., NACOOCHEE, GA.

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By this term I mean membranous croup, in contradistinction to the spasmodic form; and in what I shall say on this subject I shall not claim entire originality, but endeavor to bring forward and enforce upon the minds of practitioners some facts that if well observed and carried out will prove a source of utility and comfort to such as may have to treat this formidable disease. If I can present these facts and the method of treatment so as to make them as clear to the minds of those who read as they are to my own, and can enlist general belief in the statement, I shall have accomplished my object and shall have done a good work.

I will not discuss the question of the identity of membranous croup and diphtheria, or whether or not all cases of croup are



diphtheritic in character. I do not believe they are, but be this as it may, I shall now use the same treatment in the main for both. During most of the past this disease has been an *opprobrium medicorum*, and that no one treatment is acknowledged and followed as effective and reliable is manifest in the fact that so many different and varying formulas are being successively and from time to time proposed. I am now glad to believe that this state of things need not be perpetuated. In former years I myself regarded an established case of croup as about equivalent to a death warrant, but now I would go about the treatment of a case, not too long delayed, with nearly as much confidence as I would a case of remitting fever with plenty of quinine in my possession.

The pathology and symptoms are too well known to require notice here, but in reference to the treatment let it first be stated what should not be done, for now I eschew almost entirely the practice I formerly most trusted, that is, the administration of emetics, especially that form of them composed of tartar emetic. Do not give them. Persistent emesis is distressing and prostrating to the child, and, except in very rare instances, is ineffectual and unsuccessful. Neither, as a general rule, or scarcely at all, should purgatives be administered in the beginning of the treatment with object of catharsis, for this would interfere with the proper administration and the desired action and effect of the main remedy, the remedy most to be relied on and persisted in.

The indication for the treatment, in my view of the case, is to so affect the blood and the diseased locality as, first, to arrest the continuance of the deposit in the larynx and trachea, and, second, to soften and dissolve or loosen that which has already been exuded, so that it may be expelled by an effort of coughing. Can this be done? My experience teaches me that it can. In past time some of the fathers were known to proclaim that calomel was the sheet-anchor, and I have no doubt they sometime succeeded with it, but not often. How did they administer it? Usually in large doses, hence in purgative doses, and herein was the failure. It was too speedily expelled from the system. They did not, it seems, fully apprehend the philosophy of its

effect, that is, of its curative effect. They desired its purgative effect, and it possessed in their eyes a sort of hidden magic. They gave it in purgative doses, but we may suppose in some cases it would remain long enough in the child's stomach to be absorbed and produce the necessary constitutional and salutary effect, and hence their occasional success, enough to make them believe it a useful remedy; but by want of proper manipulation, and by reason of other influences brought to bear against calomel fifty or sixty years ago by a set of arrant quacks and impostors (the Thompsonians), it fell into some little disrepute and failed to be graded into proper line and to be established as *the* remedy for membranous croup. In the hands of the profession it did not grow into the full stature of its inherent capacity, and it is safe to say it has not even done so yet. Let us hope this may not remain true indefinitely. How then shall we proceed to secure its curative effect, since calomel is the remedy?

In the first place, let it be remembered it is not to be given in purgative doses, for this would prevent its curative effect. It must be given in a way to secure its permeating and modifying effect upon the circulating fluids and the systemic condition; and to this end it should be given in small doses and frequently repeated. A child from one to three years old, after having a dose of two grains (or even three grains if there has been delay), should be given one grain every hour, promptly, persistently and without failure. If any of this one grain is wasted, let enough be added to make up for waste. If these doses incline to purge, add a little paregoric or a drop or two of laudanum to prevent. If a dose is thrown up or rejected, replace with another dose immediately. As auxiliary treatment I usually administer also a febrifuge like this:

R. Sweet nitre,  
Antim. wine,  
Syrup ipecac,  
Paregoric, aa q. s.

M.—From half to a teaspoonful two to four hours apart.

If there is much febrile excitement, I generally use two or three drops veratrum viride three or four hours apart to restrain

the circulation, and in addition to these I use and advise a small blistering plaster over the larynx or upper windpipe. These latter measures are resorted to as precautionary, but the chief reliance is placed in the calomel.

During the first hours of this treatment the symptoms may seem to march steadily on towards suffocation, but if properly administered and persisted in, the physician or friends will usually, in the course of twelve or fifteen hours, have the pleasure of observing a marked change for the better in the progress of the symptoms, the sound of the breathing will indicate a growing looseness in the obstruction, and after this, by an effort of the child—a smart struggle, it may be—the accumulation will be forced up into the mouth and may be wiped out, or perhaps may be swallowed, but in either case greatly to the relief of the patient. It is gratifying, aye, it is simply beautiful, to witness the effect of the treatment, the manner in which the obstruction is broken up, and the change from the condition of impending suffocation to that of comparative freedom of respiration. When this occurs the calomel should be discontinued and some action of the bowels procured. There is but little danger of salivation, but it would be preferable to suffocation. I have not known it to occur.

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## TREATMENT OF GLEET AND SEXUAL NEURASTHENIA BY MEANS OF METALLIC BOUGIES.

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BY CHARLES SZADEK, M. D.,  
KIEFF, RUSSIA.

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The extraordinary difficulty of healing some cases of gleet is well known. There are men who have every morning an exudation, although they have tried every possible remedy against the evil. Frequently, especially after coitus or excess in saccho, the chronic disease becomes acute, which often leads to disagreeable results.

The product of the chronic inflammation of the urethra is an infiltration of the cells of the diseased mucous membrane ; the

infiltration gradually becomes fibrous tissue, which, in its turn, produces the cicatrization called stricture; the upper cells of this stratum, constantly sloughing, exfoliating and mingling with the mucous secretion of the glands, constitute the exudation which characterizes chronic gonorrhœa (gleet); the glands and lacunæ of the urethra are also affected. It is clear that many chronic gonorrhœas already represent the first stages of stricture, or, as Otis calls them "large sized strictures," which naturally cannot be cured by astringent solutions, or even such as are fatal to gonococci. If they are to be cured local pressure must be used to remove the cell infiltration, while medical treatment is adopted to affect the catarrh. For these reasons treatment with metallic bougies against chronic gonorrhœa has been mostly practiced.

In four years (1887-1890) I have treated fifty (50) cases of inveterate gleet with most satisfactory results, by the introduction into the urethra of Beniqué's duly curved tin bougies, anointed with either Unna's

Ol. cacao.....	1,0
Ceræ flavæ.....	2,0-5,0
Bals. peruv.....	2,0
Arg. nit.....	1,0
M.; f. ung.	

Or Sperling's Salve:

Lanolini....	20,0
Ceræ albæ.....	4,0
Arg. nit.....	0,1-0,3
M.; f. ung.	

These bougies are slightly conical and eleven centimeters in length. In nervous or very sensitive subjects, in whom the insertion of the bougies gives rise to pain and erection, from 3 to 5 per cent. solution of cocaine should be previously injected into the urethra; during the first sitting the bougie is left *in situ* not longer than for three or five minutes, but later on the duration of the sitting is gradually increased up to fifteen or even twenty minutes. The sittings are repeated every two or three days, except in very inveterate and atonic cases, in which a daily in-

troductio of the instrument is advisable. I have used a set of the bougies from No. 18 to No. 30 charriere, commencing with the least irritating bougies and gradually ascending to even larger ones. In relatively recent and in old cases I have usually employed Nos. 22, 24 and 25, while in more severe and protracted ones (which, by the way, constitute a vast majority) I have passed, following Professor Otis's instance, by degrees to No. 28 or even No. 30. In patients with narrowed ureter, I have enlarged the latter by means of a bistoury. In such cases where the lesions are situated in the bulbous or the posterior division of the urethra, his bougies should be introduced even as far backwards as the bladder; according to my experience, the deep insertion, when practiced with due caution and carefulness, never causes any untoward accessory effects (such as vesical or urethral irritation, urethral fever, etc.) The therapeutic results which I have obtained with this treatment are satisfactory. My fifty cases of gleet, which were treated after the mechanical method, in five cases of urethritis posterior, complicated with obstinate vesical affection, the results were far from being satisfactory; but in the remaining forty-five the treatment by metallic bougies proved highly successful. In thirty of the fifty cases a complete cure ensued; in another case a considerable improvement was obtained, and the only symptom left was a scanty mucoid discharge recurring from time to time. In relatively recent or in old cases from four to eight sittings proved to be sufficient for effecting cure. In a majority of cases, however, two or three months' course was necessary for the purpose, while in some unusually severe case, complicated with multiple strictures where a relapse took place, another course was to be repeated some months later.

The same method in the shape of the insertion of Nos. 20 to 30 gave to me most gratifying results, also, in fifteen cases of sexual asthenia, with spermatorrhœa and incomplete sexual impotence.

I arrive at the following general conclusions:

1. The method under consideration proves very useful: in many cases of neurasthenic irritation of the urethral mucous membrane, and in many cases of inveterate gleet, especially in

those characterized by infiltration and other morbid changes in the mucous membrane and submucous tissues.

2. It proves beneficial further in inveterate gleet of an atonic character, or in that kept up by local nervous disturbances.

3. In some cases, however, the mechanical treatment must be supplemented by a subsequent course of local astringent remedies.

4. The method is free from any untoward accessory effects; provided, it is practiced with due precautions.

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### DID QUININE KILL THEM?

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J. R. G. HOWELL, M. D., DOTHAN, ALA.

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In the February number of the JOURNAL, page 712, I notice an article by E. H. Martin, M. D., of Hillhouse, Miss., commenting on and criticising my nomenclature and treatment of malarial hæmoglobinuria in the December number of the JOURNAL, page 609. His criticism of the term hæmorrhagic malarial fever is well sustained, for the term is an inappropriate one. But as I am not the author of it, I am not responsible for its origin. The criticism of the use of quinine in the treatment of said disease is the part of his article I am going to answer. Dr. M. censures me for not being able to see that quinine is contra-indicated in malarial hæmoglobinuria. I wish to show:

1. That quinine is not the cause of malarial hæmoglobinuria.
2. That quinine was not the cause of the fatal results in cases I., II., III. and IV., reported by Dr. M., as he attempts to show.
3. That calomel was the drug that killed them.

It is a fact that quinine is sometimes, but *not always* given previous to attacks of said disease. Also are calomel, arsenic, salicylic acid and many other remedies. Why? Because the patients are in a malarial district. Now is this any reliable reason for calling the ill that may occur in the future, a case of quinine hæmoglobinuria or calomel hæmoglobinuria, or any other

name that would imply that a given drug was the cause of the disease. The patient is in a malarial district, under malarial surroundings, and breathing malaria. This is plain but strange evidence that malaria is the cause.

Dr. M. makes inquiry just far enough to find out that his patient has been taking quinine, and there he ceases his inquiry, satisfied that he had a case of "quinine hæmoglobinuria."

The following table of Feraud will prove very conclusively the second and third propositions of my article. For this table I am indebted to Dr. H. McHatton, of Macon, Ga.:

	Cases.	Deaths.	Per cent.	
a	71	22	31	{ Quinine in very small doses. Calomel purgative.
d	11	4	36	{ Quinine very small doses. Calomel and other purgatives base of treatment.
e	42	13	31	{ Quinine very small doses. Calomel and other purgatives base of treatment.
f	30	9	30	{ Quinine very small doses. Calomel and other purgatives base of ment.
b	40	8	20	{ Quinine in medium doses. Calomel in small doses.
c	29	5	17	
g	27	3	17	
h	18	2	11	{ Quinine in large doses.
i	18	0	0	

As before said, this table shows that quinine in large doses is the remedy for the disease in question. It also shows that calomel is the poison. We can see the same truth very prominent in the eleven cases reported by Dr. Martin. We see that in cases I., II., III. and IV., he gave both quinine and calomel. They all died. Now, why does Dr. M. charge all his bad luck up to quinine? Why charge any of it to that grand old remedy? In case I., we see on the 11th, Dr. M. gave calomel in four grain doses, repeated every hour until six doses were given! We also see on the 14th, his patient "flickered out," as he describes it. We also see that patients II., III. and IV. had calomel in alarming quantities (for calomel is always alarming in malarial hæmaturia), and they all died promptly. He acknowledges, by accusing me of the same error, the fact that he gave alternately a poison and an antidote, but alas! his poison, we see, was too powerful.

He censures me for not seeing that I was killing my patient with quinine. I gave quinine without calomel, and that as well as all the other cases coming under my treatment recovered as speedily as heart could wish for.

Dr. M. treated his remaining seven cases without either quinine or calomel, and as might have been expected, he lost some and some *got well*. Now I am perfectly willing for Dr. M. to name the disease "*Lysæmia*," provided he will notice the use of quinine and the abuse of calomel in malarial hæmoglobinuria.

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## TREATMENT OF MALARIAL HÆMATURIA.

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BY B. W. MASON, M. D., SHERIDAN, ARK.

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In copy of JOURNAL for February I notice an article on the treatment of "*Malarial Hæmaturia*." The author of this article recommends the use of tincture iron mur. and Fowler's solution. Since I have been in Arkansas I have treated five cases of this disease; two of these cases were very bad, one died, the other three cases were seen early and all recovered. My treatment, was calomel, elixir, vitriol and ergot and buchu. Of these five cases only one was salivated, (very slightly); case recovered. While glancing over the JOURNAL that contained the above mentioned article, a gentleman came for me in great haste to see his child. I found the patient, a girl nine years old, who had been having chills for more than a year. Skin very yellow, pulse 135, temperature 102, bowels had been moved by a dose of salts, the bladder acting every hour or two, passing dark blood. The child complained of pain in head, back and bones of lower extremities. She was vomiting almost incessantly and the dyspnœa was so great that she had to be raised to a sitting posture and fanned frequently; this was to me an alarming symptom. I at once put her upon one grain doses of calomel every two hours until the bowels were acted upon; for the nausea I gave Hors-



ford's acid phosphate, which acted nicely. I gave tincture iron three drops, Fowler's solution one drop every two hours, and spirits turpentine four drops every two hours. This treatment was commenced Tuesday at 11 o'clock A. M. At 8 o'clock P. M. the urine began to look more natural, the skin to clear up, the nausea to subside. The last trace of blood in the urine disappeared at 9 o'clock A. M. Wednesday. Not a trace was to be discovered in discharge from the bladder two hours later. The patient began to improve and I discharged the case Saturday so far recovered as to sit up a little. I left a tonic for her and she made a quick and nice recovery. I think the iron and arsenic treatment will do.

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## YELLOW FEVER AND THE FALLACY OF THE GERM THEORY IN CONNECTION WITH ITS SPREAD AND EPIDEMICITY.

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BY JOHN P. WALL, M. D., TAMPA, FLA.

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Since the subject of bacteriology has received so much attention from the medical profession, it has naturally assumed a prominent position in the causation of disease, as an evolution of the germ theory, in explanation of the cause of fevers.

The bacillus for this and the coccus for that disease are now almost universally accepted as the pathogenic causes on the evidence simply of some *ipse dixit* who busies himself with infinitesimals through a powerful microscope and culture media. So far no practical result in the prevention or management of human ailments has been realized, while it has had a demoralizing tendency on both the profession and the general public—on the profession in inducing a theoretical practice, and on the public in misleading it to accept as proven the vague theories held by the profession of medicine on the germ theory. The general public talks about the germs or microbes of diseases with all the earnestness and credulity of proven facts; and, as a result, have un-

bounded faith in disinfectants and germicides to prevent the spread of contagious and infectious diseases.

Now the truth is, very little is known with certainty about pathogenic germs ; and where micro-organisms are found in diseases, the question naturally arises as to whether such micro-organisms are the cause or the result of the disease in question. The labors of a few able but over-enthusiastic men have impressed on the majority of the profession the theories for proven truths. Time and experience have not demonstrated the teachings of Lister and Pasteur to be correct, though it is possible that their teachings have been somewhat beneficial in promoting new departures from old methods. It may be only necessary to point out the fact that the antiseptic measures of Lister to exclude atmospheric germs as a cause of suppuration, have resulted in aseptic measures based on cleanliness ; and that the so-called vaccination of Pasteur for chicken cholera and charbon have not yielded the protective results so confidently predicted and at one time believed ; and that his rabietic vaccinations do not possess the efficacy in preventing hydrophobia as claimed by him and his disciples. The discovery of the cholera bacillus by Koch has led to no practical result ; and the same may be safely predicated of his tubercule bacillus and his present experimental essays at curing consumption, as meagerly detailed in the daily press.

In view of how little is positively known in support of the germ theory—which at best can only be considered a mere hypothesis of contagious or infectious poison being a particulate matter—it is neither wise nor judicious to place such credence in it as to conform our practice in the treatment or prevention of disease to it ; in short, to accept it as a principle that all treatment or prevention of disease depends on the use of a germicide. This point is about reached by that enthusiastic majority of the profession, especially its junior members, who affect to believe the practice of medicine in the curing of disease to be a science instead of an art, as it always has been and will probably remain.

In short, the germ theory is probably as fallacious as many other theories which have sprung up in medicine, been accepted

and flourished for awhile, to be finally forgotten or only remembered as curiosities of medical literature. That there may be micro-organisms developed in disease may be assumed as an indisputable fact, but instead of their being pathogenic causes, is it not more probable that the development of these micro-organisms is the result of a retrograde metamorphosis in the process of destruction—the necessary concomitant of a lowered vitality in disease ?

The idea of inoculating with attenuated germs by successive cultures or a process of more or less partial desiccation has no analogy whatever to the vaccination for smallpox, because in the latter a virus of a specific character is used, which experience alone has demonstrated to be efficacious, the same as it has that mercury is the remedy for syphilis, or that numerous other drugs produce specific effects, the rationale of which is not understood. We know that it is so, and that is all.

Finally, it may be affirmed that, even admitting the existence of specific germs of certain diseases, these germs have to be introduced into the body of another to insure their potency in producing the same disease ; and as this is most usually accomplished by contact with, or close approximation of the healthy to the sick, such diseases are known as contagious. On the other hand, infectious diseases are dependent on a general morbid agency in the atmosphere, and are not dependent on personal contact.

So much by way of preface is deemed necessary for a correct understanding of the extent of our positive knowledge in regard to germs and the germ theory, before proceeding to discuss the chief epidemic disease which occasionally prevails in the cities of the South, to-wit, yellow fever, and the most rational means to prevent its introduction and spread. It has so far failed of demonstration or proof that yellow fever is a germ disease, notwithstanding the fact that most recent authors speak of it as such. That yellow fever is occasioned by a specific poison is unquestionably a fact, and that this poison is given off by a person sick with the disease is doubtless equally true ; but this morbid emanation may be rather compared to odors which, so far, have

eluded detection, if of a particulate nature, than assumed to be vital germs. Besides, my observations have convinced me that there has to be in the atmosphere of the locality the presence of some hitherto unknown factor, to render it susceptible of becoming infectious ; *i. e.*, in other words, to produce an epidemic after the introduction of the poison. What this unknown factor in the atmosphere of the locality is dependent upon is a mere matter of conjecture. We know, however, that it usually pertains to urban populations, and hence has generally been attributed to the presence of human filth. And while this may be so, I am very well satisfied that it is not always the case, but can offer no explanation other than that of Pettenkoffer, who speaks of certain localities having the "disposition" for the spread of epidemic diseases. It is a matter of observation that on the introduction into a place of a case of yellow fever, the disease does not spread by contact with unacclimated persons, and that it will generally be noticed, where the presence of the first case has been positively known, that some time, probably a week or more, will elapse before another or other cases will make their appearance, thereby clearly indicating that the poison emanating from the sick does not possess contagious properties and may prove inert in producing a general local atmospheric epidemic condition, unless there is present this unknown factor—this "disposition" of Pettenkoffer—necessary for the poison to leaven the whole, as it were. Again, another curious fact about the infection of yellow fever is the tenacity of the infection to the locality for a considerable length of time. This is observed in the case of ships, notwithstanding the fact of their departure from the infected port and sailing through the pure atmosphere of mid-ocean, where there is none of the accumulated filth of cities or towns. And this occurred, too, in 1888, in the case of the United States war vessels visiting the ports of Hayti, where it may be fairly presumed the ships were kept in a good sanitary condition, and all reasonable precautions taken to prevent their becoming infected. It is very evident, then, that it is the locality—whether a house, ship or town—which becomes infected with the poison of the disease ; and that those susceptible, if exposed in the in-

fectured locality, run the risk of contracting the disease. That there is no contagion from mere personal contact in yellow fever, as in the case of the exanthematous fevers, has been admitted by all observers of large experience with the disease, with few exceptions, for the last hundred years. And, again, in support of the view that yellow fever is not a contagious disease, it is only necessary to bear in mind the fact that season, altitude and locality even influence for or against its epidemicity—conditions that have no influence whatever on the spread of contagious diseases. Nor is there any better evidence in support of the idea of contingent or miasmatic-contagion than there is of contagion simple and pure in this disease. It may be further admitted as an established fact, that the infective principle or poison emitted from the sick with yellow fever becomes attached to goods or clothing, and retains its morbid potency for some time, the length of which is entirely dependent on its exclusion from a free airing. It is moreover highly probable that for goods or clothing to become such fomites, it is necessary for sick persons with the disease to be in the same room or building.

That epidemicity of yellow fever is dependent on a high temperature is a characteristic fact of coeval recognition with the disease itself; and even in tropical climates where the disease has become endemic, its epidemicity is only noted during the hot season of the year. In such climates the temperature never falls to the freezing point, which observation has abundantly demonstrated to be sufficient to purify the infected atmosphere of a locality; though, unless such a low temperature is continuous for some time, it may not be sufficient to destroy the infection in dwellings; and then the disease may continue in sporadic cases contracted in such infected dwellings until the following hot season, again to become epidemic if sufficient unacclimated material is in the place. And thus, too, dwellings closed and abandoned during the prevalence of an epidemic may possibly retain the infection for some time after the general infection has disappeared; but this I am inclined to doubt. The idea of the hibernation of the specific infection of yellow fever without the occurrence of sporadic cases during the winter, I feel fully convinced is a fallacy,

at least in any part of the United States. And it is only in the winter season that isolation and disinfection in the management of these sporadic cases will prove of any benefit whatever. By the timely recognition and proper management of these sporadic cases during the cool season, the disease can be stamped out and its recurrence prevented the following warm season. But where the locality has the "disposition" for the spread of the infection isolation and disinfection will prove totally unavailing in preventing an epidemic during the warm season of summer and autumn, provided the disease is introduced. Of course this isolation and destruction of goods, with the use of the so-called germicides in the way of disinfection, may get the credit of having averted an epidemic in places lacking the "disposition"—the unknown necessary factor—for an epidemic spread of the disease.

As regards disinfectants it may be safely affirmed that their efficacy, like the supposed pathogenic micro-organisms for whose destruction they are used, is largely hypothetical. Even the dioxide of sulphur, which, for almost ages, has been mainly relied on for disinfecting purposes, is now acknowledged to possess no such germicidal property, and during the current year leading medical journals have slurred at it, and asked how long it will be before it is relegated to limbo by the sanitarians? Thus we see how long a delusion has held full sway over scientific (?) minds to the general satisfaction of the profession and the public. What a commentary on our boasted science! And of the many other so-called germicides that have been discovered to possess such properties since Lister first introduced carbolic acid as such, is it not probable that none of them possess any more efficacy as germicides than sulphur? Besides, so far the use of disinfectants to destroy the infection of yellow fever is purely theoretical, as no germ of the disease has been discovered, though some may have deluded themselves in the belief that they had. The use of gases for disinfecting purposes may probably do some good by displacing the stagnant atmosphere in a ship or in a room, but beyond this their utility is probably *nil*, or at least problematical. And it is a question whether or not the same end might not be attained by the introduction of pure fresh air. In

fact, it is admitted that aeration is a disinfectant; and it is more than likely that the exposure of baggage and goods to the fresh air in their manipulation at quarantine stations in the process of their submission to disinfecting agents, is in truth the disinfectant after all, so far as the infection of yellow fever is concerned. In fact the exposure of baggage to air for its disinfection in case of yellow fever was suggested and recommended several years ago by Dr. Henry F. Campbell, of Augusta, Ga., in a paper published by the A. P. H. Association. And it must have occurred to every one who has witnessed the prefatory sulphur fumigation at quarantine stations along lines of railroads during an epidemic of yellow fever, to note its farcical character and total unreliability. In 1887 a fumigating station was maintained between Tampa and Plant City from about the 10th of October till about the 20th of November, when all the time cases of yellow fever were occurring in a small hotel in Plant City, which latter place was free from communication by rail with the remainder of the State. No one sick with the disease in Plant City died till the 14th day of November, and even after that no quarantine was instituted against Plant City that year. This is mentioned as showing the absurdity of land quarantine; and many other instances of a like character within my knowledge occurred in Florida during the epidemic of 1887 and 1888. Land quarantines have been pronounced useless by all recent International Sanitary Conferences; and it does seem that the time has about arrived when health officers should begin to appreciate an expression of the collective wisdom based on experience of the civilized world; and cease to magnify their importance by countenancing the absurd and ridiculous measures of a false teaching. The general disinfection and destruction of goods, *et cetera*, practiced in Florida in 1887-'88, was nothing more nor less than a recurrence to the same absurd measures practiced in Philadelphia in 1793, which time and experience demonstrated to be worse than futile. And even in the most southern State of the Union the same fact has been most fully demonstrated under my own observation, so that it is to be hoped that no such folly will be perpetrated again under the sanction of medical authority.

And here it may not be amiss to refute the general prevalent idea obtaining in the public mind as to the great mortality from yellow fever. During an epidemic a considerable proportion of the cases are so mild as not to require the services of a physician, the disease proving to be a mere ephemeral fever of from one to three days' duration. The popular idea among people who have never passed through an epidemic that all subjects of yellow fever are violently ill and only recover by the skin of their teeth, as it were, is the main popular fallacy which has inspired such terror of the disease and occasioned such panics. The mortality of yellow fever in this country is no greater than that of other fevers, rarely exceeding ten per cent. But in consequence of an epidemic running its course in from sixty to ninety days, the number of sick and deaths in an unacclimated population is necessarily large during that period of time, though the proportion of deaths to the number of cases will rarely exceed, as before stated, ten per cent. And even this great mortality is in a great measure due to the fact that the epidemic is largely incident to the poorer classes who have not the means to follow the example of those with means who get away from the infected locality as soon as they become convinced of the true nature of the disease. Consequently many of those remaining and falling sick receive neither proper medical attention nor nursing and care. The late Dr. Bemiss estimates that the percentage of deaths in New Orleans in 1878 among those families who were able to provide medical attention and nursing did not exceed from seven to ten per cent. Besides, the numerous mild cases to which a physician may not have been called are never reported. For instance, I have repeatedly found, on being called in to see one member of a family, that several members of it had already had the disease and convalesced under domestic treatment; and that probably only one or two in a large family would be at all seriously ill. And here it may be stated that no case of yellow fever is, as a rule, serious unless it is complicated with an acute nephritis and albumen is noted in the urine by the third or fourth day, sometimes earlier than the third day in very bad cases,



though not very frequently. And, moreover, it is only in cases with the nephritic complication that the icteric hue or color is developed which gives this fever its name—yellow fever.

The number of those exposed in an infected place who have the fever after leaving it is very small. According to the report on Camp Perry of Dr. Guiteras during the epidemic in Jacksonville in 1888, one thousand two hundred and eight persons were subjected to ten days' quarantine detention at that place. There were thirty-six cases of the fever during the time at Camp Perry, though two of these, already sick, were brought there from Uptonville, in Georgia, leaving thirty-four cases; and of these five sick were from Callahan and one sick from Fernandina and four sick from Jacksonville; thus reducing the number occurring among refugees proper to twenty-four—hardly two per cent. It must be remembered that Camp Perry only became a refugee quarantine station to any extent some weeks after the epidemic was in full vigor in Jacksonville. According to the same authority no one contracted the disease at Camp Perry from coming in contact with the sick, thus demonstrating and proving two important facts: First, that yellow fever is not contagious, and second, that Pettenkoffer's "disposition" in the locality for its spread was lacking. The same thing was also witnessed at the Sand-Hill Hospital, four miles from Jacksonville, where the unacclimated attendants did not contract the fever, though some of them subsequently had it in Jacksonville after a few days' sojourn in the infected atmosphere of that city. It is thus seen how few fall sick after leaving the infected locality.

To prevent the introduction of yellow fever into the Gulf and South Atlantic ports from the tropical regions south of us, a system of inspection at the infected port to exclude from passage and transportation unacclimated persons and infected baggage and household goods, offers the most certain and satisfactory method. No matter what quarantine system is established at our own ports, such can never afford as much security as a system of exclusion at the foreign infected port. This is especially true in regard to regular passenger steamers. For mere trading vessels and steamers which have remained in the infected

port for days or weeks, an inspection at a quarantine station would be necessary; and such vessels should be cleared to touch first at some government quarantine station before entering any southern port. It will always be found impossible for any quarantine station at any port to be conducted in a manner thoroughly satisfactory to remote places having communication by rapid transit with that particular seaport. Even New York's quarantine has been a subject of animadversion when cholera is prevailing in Europe; and the same would be the case in regard to yellow fever, but for the fact of that and other northern cities having been so long exempt from an epidemic of that disease.

As to preventing the spread of yellow fever from an infected city or town in the yellow fever belt of the Southern States, the problem is an extremely difficult one; and this difficulty is greatly enhanced by the terrors of the disease inspired in the public mind in latter years by the profession and the daily press. Panics are not only to be deprecated but if possible prevented by diffusing more correct ideas of the character of the disease, and disabusing the public mind as to its great mortality. Thus it is to be hoped unseemly panics may be prevented, and those wishing to leave an infected locality might be enabled to do so in an orderly way. A refuge camp a few miles from the infected city might be provided for a few days' detention of the unacclimated and the airing of baggage; though baggage from houses in which have occurred cases of fever, should not be permitted carried out of the infected locality. Airing and exposure of baggage to the hot sun for a few days would doubtless be found just as efficient in relieving articles of clothing of any slight infection contracted from the general atmospheric infection of the locality as any other means that could be devised, to say nothing of the damage to many articles of clothing by subjecting them to disinfecting processes.

Isolation of the very few who might fall sick in the refuge camp after leaving the infected locality should, of course, be provided for as a matter of precaution. But while this programme appears easy of accomplishment, its execution is surrounded with many inherent difficulties growing out of the indi-

vidual independence naturally pertaining to American citizenship. Sanitary cordons are a humbug as a safeguard in preventing ingress into or egress out of the infected locality.

During the civil war yellow fever was epidemic in Charleston in 1864. In those days no such thing as a land quarantine was ever heard or thought of in this country. Troops were continually passing in and out, and one or more wayside hospitals for furloughed sick and wounded soldiers were open in the city, where the feeble not able to endure the continuous travel to their homes in other Southern States, could stop over for rest or treatment. Great numbers availed themselves of this wayside hospital for short periods of a few days to a week, and proceeded on their journeys to their homes. Communication with Savannah and other cities by rail was daily, and yet no one thought of such an absurd thing as a land quarantine. Nor did the fever prevail at any other points in the South that season. The same state of facts was experienced in Wilmington, N. C., in 1862, except as to the wayside hospitals, communication being maintained with the infected city during the prevalence of the epidemic.

Nor is there the least foundation for the belief that the disease can be contracted from the dead of yellow fever, for I remember distinctly to have seen subjects who died with the disease, on the dissecting tables of the medical college in Charleston in 1856, when I had the honor of being a student of medicine of the institution. It was even claimed by some of the writers in the first half of the present century that there was no risk of spreading the infection in a city from the introduction of the sick, provided the sick were introduced in a nude condition, deprived of all clothing; and Dr. Cartwright mentions that this method was practiced with safety in Memphis in the transportation of the sick from the New Orleans steamers to the Marine hospital. These facts are deemed important in refuting the absurd notion now obtaining to some extent, of the yellow fever infection being dormant for years in cemeteries where its victims have been buried, to be resuscitated by disturbing the graves. The hasty and often indecent burial of the dead under the false

idea of speedily getting rid of an intensified infective focus, is another absurdity of the present day to be reprobated as equally repugnant to truth, human sympathy and Christian sentiment, to say nothing of the increased terrors of the disease inspired by a knowledge of such a barbarous practice, not only in the minds of the sick, but of those still well, possessing no immunity from a previous attack.

In conclusion, while acknowledging that the laws governing the origin and spread of yellow fever are unknown, it is nevertheless our duty to make the hygienic condition of towns and cities exposed to its invasion as perfect as possible in the hope of eliminating the unknown factor, the "disposition," whose presence is essential for its epidemicity. In the direction of sanitary improvement should the hope and expectation of the public be directed, rather than to a reliance on quarantine measures instituted in our own ports. And even Dr. Holt, since his retirement from the Board of Health of Louisiana, has emphatically declared that "New Orleans to be saved must be cleaned and drained," though only a few years since, as a health officer, he appeared to have perfect confidence in his system. If New Orleans can only be saved by being cleaned and drained, whence the necessity for all this furor about the Holt System? During the quarantine season of last year a case of yellow fever got into New Orleans by way of shipping through her quarantine; but that no epidemic followed was by no means due to her efficient (?) quarantine.

When it is remembered the exceedingly small percentage of unacclimated taking sick after leaving an infected locality, and the benefits derived from the inspection of passenger steamers in Havana by a medical officer of the Marine Hospital service, it is quite probable that New Orleans' exemption from an epidemic during the last decade is rather dependent on these latter circumstances than due to her quarantine system. In fact, since the Holt system was put in operation I do not think that any cases of yellow fever have been reported at her quarantine station, or at least none arriving on the regular passenger steamers

of the Morgan Line; and consequently the natural inference is that it has proven wholly unnecessary so far as passenger steamers are concerned. This, too, has been demonstrated at Tampa during the past six years.

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## "HIP JOINT DISEASE."

BY P. H. FITZHUGH, M. D.

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**SYNONYMS:** Morbus Coxarius; Morbus Coxæ; Hip Disease; Tuberculous Disease of the Hip; Chronic Epiphysitis of the Hip; Medello-Arthritis; Coxalgia; Coxitis; Chronic Articular Ostitis of the Hip; Coxo-tuberculose (Lannalongue).

Webster defines the hip as "the projecting part of the trunk of an animal formed by the lateral parts of the pelvis and the hip joint with the flesh covering them; the haunch."

Gould gives as the hip, "the upper part of the thigh at its junction with the buttocks."

Haunch is "that part of the body including the hips and buttocks."—(Gould.)

Webster gives as the definition of haunch "the hip, that part of the body of man and quadrupeds which lies between the last ribs and the thigh."

From the above definitions it will be seen that the term hip, is employed rather indefinitely by the profession as well as the laity, to include not only the immediate structures which enter into the formation of the joint proper, but also those both hard and soft which contribute to the function and protection of the same, even to the fascia and integument.

From this wide range confusion in properly classifying diseases of and about the joint arises.

For instance, when one makes the assertion that he has cured a case of hip-disease with restoration to perfect function, you will frequently learn on questioning that he can give no absolute

anatomical grounds for his diagnosis. The fact is, that, so long as our definition of hip is this broad, just so long will the term hip-disease be misleading, for a scratch, a bruise, a boil, anywhere from about the upper quarter of the thigh to and including the pelvis is on the hip.

It is all important for the orthopedist to acquaint himself from personal observation of the contour of a normally formed hip, the appearance of the lines and dimples into which it is thrown, as the subject assumes different attitudes. I can do no better than quote from Dr. Gibney on this subject.

“The prominences of the nates of course stand more conspicuously as the erect position is assumed; the fullness or flabbiness indicating health or the reverse. In the normal state we must find absolute symmetry in the prominences and depressions. The eye then takes in the gluteal fold, which must not deflect to one or the other side; the supra-trochanteric dimples or depressions which vary in depth and area according to the leanness or obesity of the subject, preserving, however, in any instance a symmetrical appearance; the glutea-femoral folds, marked by fissures or creases indicating the junction posteriorly of the thigh with the trunk. These creases vary, too, according to the muscular or adipose development of the individual. As a rule the fissure is a bifurcated one, the upper curvilinear being the longer and extending from the perineum to the junction of the posterior with the anterior surface of the thigh, while the lower, nearly straight being shorter by one-half and leaving the upper about an inch from its femoral extremity, to extend an inch or two diagonally down the posterior aspect of the thigh. . . . We remember, too, that the law of symmetry must be recognized even in the fissures. Indeed, one can but admire the symmetrical arrangement of the lines and prominences so exquisitely drawn by nature in a pair of hips free from disease or deformity.

“One must not rest content with studying the parts already mentioned, but the eye will take in at a comparative glance the position of the trochanteric-prominence, the sacral region, the ilio-costal spaces and their relationship to the crista ilii, the size of

the thighs in the upper one-third, and indeed, all the regions immediately connected with the hip. Soon one learns to observe all this at a glance and easily detects any departure, however slight, from the law of symmetry."

#### PATHOLOGY.

Hip disease begins most frequently as an ostitis and originates rarely as a synovitis. It has, however, from time to time been considered by various writers to originate in the synovial membrane, ligamentum teres and other ligaments, and even at the present day teachers are not fully agreed as to the original focus, but we believe the weight of opinion is in favor of a bone origin in children, while probably a synovitic is more common in adults. Gibney, Gross, Marsh, Barwell, Rust, Bryant, König, Volkmann, Annandale, hold the osseous origin; Sayre and Billoth favor the synovial; while Owen, Holmes and others claim the ligamentous. Müller, as reported by König, analyzed specimens of sixty-one hip excisions and found in forty-seven cases osseous origin, three synovial, while in eleven he could not state the origin. Gibney reported an early autopsy in a case of double hip disease. In one joint the focus was in the head of the femur, while the other was in the acetabulum.

The process which takes place is a degenerative ostitis caused by the tubercle-bacilli; there is also a greater or less amount of formative activity, but the distinct pathological process is a degeneration.

The common form of tubercular infection of the epiphysis is the one spoken of as focal or encysted, when the first change is the formation of single or multiple foci of tubercular degeneration.

On section of the diseased epiphysis "the first noticeable change consists of a local hyperæmia of some part of the spongy tissue. There then appears in this hyperæmic area a small grayish translucent spot almost as small as one can see, which grows more and more gray and increases in size, while a zone of hyperæmic tissue develops around it, and the neighboring bone looks boggy from an excess of the transuded fluid. There is no synovitis; it is purely a localized ostitis.

"As the diseased focus grows larger it looks more yellow in spots, and shows at its center a tendency to cheesy degeneration and later in the history of the affection one finds nodules, varying in size from that of a pea to a hazlenut, which are filled with a putty like substance such as the cheesy material found elsewhere in the body, except that it contains spicules of bone from the trabeculæ, and in the larger *foci* pieces of dead bone of considerable size are found.

"Later in the history of the affection the tuberculous nodule breaks down into pus, and it is said that at this stage absorption has occurred, leaving nothing but a cavity filled with limpid serum." (Bradford and Lovett).

The absorption of the diseased focus is possible up to a late stage of the process, unless a sequestrum of bone of some size shall have formed; the pus becoming cheesy and calcified or possibly absorbed. Probably the most common course is for this cheesy mass to break down and discharge into the joint cavity or it may not enter the joint but break through the periosteum and discharge into the peri-articular tissues, when an abscess is formed, which, if not disturbed, will evacuate spontaneously. The disease may end with this termination, granulation and cicatrization taking place, or it may continue indefinitely, first better then worse. The writer has seen several cases in which this condition had lasted from eight to twelve years, the disease apparently being arrested for months when some imprudence would bring on an exacerbation, which may continue for from a few weeks to as many months, this followed by a remission, then another exacerbation and so on. That this condition is less apt to follow joint affections, accompanied with abscess, than those without, statistics which are now being prepared on five hundred cases of "tumor albus" extending over a period of twenty years, will show.

It is abundantly proved by the microscope revealing the bacilli, in nearly all of the specimens examined for this purpose, that the disease is due to the tubercular bacilli. They are generally found in the "giant cells." They may be few in number and hence difficult to find.



In an abscess in a case at Volkmann's Clinic, twenty sections were examined and only two bacilli found. A number of orthopedists regard every case of hip disease as tubercular, although they are difficult to detect and exist in greater number in the early or stage of invasion than during the later stage when most examinations are made.

The inoculation of tissue from a scrofulous joint or that from a tubercular lung into a healthy animal, being followed by the same general and local condition as that produced by the inoculation of the pure culture of the bacilli, renders conclusive to the writer's mind the identification of scrofula or struma and tuberculosis.

#### ETIOLOGY.

That there exists in most, if not all, cases of joint disease an hereditary predisposition the writer is pretty firmly convinced. Figures which attempt to show what proportion of children inherit this tendency are unreliable, for the class of hospital patients from whom these statistics come are loath to acknowledge any inherited diathesis. The writer believes firmly in the identification of scrofula and tuberculosis.

"Gibney on the Hip," page 204, describes scrofula or struma as follows: "Struma, then, is a diathesis in an individual, either hereditary or acquired, and which renders its subject, especially in children, peculiarly vulnerable in certain tissues, viz.: the mucous membrane, the skin, the lymphatic system and the bones, and the inflammation which is so easily induced in the tissues named is remarkable for its great pertinacity and for products which are notably cellular in character, which present certain peculiar properties when inoculated in animals, and which instead of terminating in resolution or suppuration, extend locally and infect adjacent parts, developing either into tubercles or degenerating into caseation. "Call this diathesis a tendency if you will; it can scarcely be called a disease." The following quoted from Bradford and Lovett, proves that tuberculosis can be transmitted from parent to offspring:

"Landouzy and Martin, taking a six and one-half months' foetus born of a phthisical mother, found it to all appearances

perfectly free from tuberculosis; yet a piece of its lung put into a guinea pig's stomach caused general tuberculosis in four months, and inoculation was then carried through five animals. The cardiac blood from another foetus caused the same tuberculosis in other guinea pigs. Again, one of these tuberculous guinea pigs gave birth to a litter, and a young one two days old was killed and appeared perfectly healthy; yet, pieces of its viscera inoculated into other guinea pigs caused general tuberculosis. And finally, the semen of a guinea pig thus rendered tuberculous was removed from the vesiculæ seminales with much care, and being inoculated into other guinea pigs caused tuberculosis."

Gibney analyzed 596 cases of joint diseases and found tuberculosis in one or both parents in 60 per cent.; an "acquired diathesis" in 30 per cent. He could only find one case which did not present either an inherited or acquired diathesis.

From the Alexander hospital of reports of 401 cases of hip disease, 24 per cent. had phthisis in the family history, and 35 per cent. were classed as traumatic.

Dr. C. F. Taylor, of New York, found in 845 cases of Pott's disease, 34 per cent. with a tubercular or scrofulous disease in the parents, and in 66 per cent. the disease came on in patients of a sickly diathesis. It has been proved that trauma to a joint of a tuberculous animal will cause tubercular joint disease where no such effect will follow in a healthy animal. This leads to the conclusion that traumatism applied to a strumous subject may be followed by tubercular joint disease, when in a healthy individual it will produce no such effect.

"Gibney observed 845 cases of spinal paralysis (a class of children subject to constant falls and injuries) for several years, and found only four complicated with joint troubles."

"Roser observed 100 children at Marburg with fracture of the elbow and in no case did tubercular disease follow."

The exanthemata are very fertile in issuing in a tuberculous joint disease. Measles and scarlatina being the most common, while diphtheria and pertussis contribute their share, especially the latter.

We may safely say that it is distinctly a disease of childhood, however; it is very rare under one year and probably never congenital. In 1880, Gibney reported 560 cases of hip disease. In 352 the disease began before the fifth year; in 290 between the third and fifth; thirty-nine after the tenth year, and only five after the thirtieth year; three at the fourteenth, and one each at the fifteenth and seventeenth years. (B. and L.)

Sex seems to play no part in the development. In 1,888 cases analyzed by Gibney, 909 were males and 909 females.

Dr. L. Emmet Holt collected 2,307 cases at the hospital for ruptured and crippled, and found 1,178 males and 1,129 females. The writer, during the past summer analyzed 470 cases of "tumor albus," and found 211 females; 259 males. Of the same 470 cases, 225 involved the right knee, 222 the left, while in twenty-three the side could not be ascertained.

Dr. Gibney, in closing the article, "Etiology in Diseases of the Hip," gives the following conclusions:

"1. A strumous diathesis, either hereditary or acquired, is the great predisposing cause of all chronic inflammatory bone lesions of the hip.

"2. That the disease may be excited by a fall or strain or wrench, exposure to cold, or by acute disease, an exanthem, for instance; with a prolonged convalescence.

"3. That in many cases no exciting cause can be found. . .

"The successful treatment of these maladies, attended by so much suffering, productive of so much deformity, much of which is often irremediable, and the mortality, . . . which is between 10 and 12 per cent., the successful treatment, I say, is the prize to the attainment of which all our labors should tend.

"That many diseases, essentially constitutional, demand local treatment, no sane man will deny; and with a proper understanding of the constitutional vice on which the local lesion depends for its existence, no sane man will assert that local treatment will meet all the indications."

#### SYMPTOMS.

It has been customary with a number of authors to divide hip disease into three stages, namely: First stage or period of in-

vation, extending between the initial lameness and the establishment of deformity ; the second stage, clinically speaking, extends from the establishment of permanent deformity due to muscular contraction to the deformity depending upon bony changes and displacements ; the third stage, that of real shortening, due mainly to the pathological changes in the bone, "the limb assuming positions consonant with the positions of the head, neck or acetabulum destroyed."—(Gibney.)

As it is not necessary to proper treatment, and as there is very little argument among writers as to what symptoms belong to each stage, it has not been deemed advisable to follow any such division.

The beginning of hip disease is generally most insidious. At first there may be only the very slightest amount of limping or stiffness of the limb on arising in the morning or after sitting for some time. In several cases the writer can call to mind, this slight limp would last a few days or weeks, then the limping would cease only to begin again in probably a week or month. This state of affairs may continue for months before medical advice is consulted. The parents consoling themselves with the thought, the child was suffering from severe "growing pains." Again, judging from histories given by parents, the disease may begin very abruptly, for I have frequently seen hips absolutely locked by muscular contraction in children who, the mother said, had been perfectly well the week previous ; but in dispensary hospital patients we are constantly reminded by their own statements that there is nothing so *unreliable* as absolute facts in regard to histories. We will admit that the disease may be more rapid of development in one than another, still we can hardly believe that a hip held firmly by muscular contraction, and probably fluctuation detected, can be the result of a week or month's disease, it matters not how severe the traumatism which may have started the pathological process.

The average case of hip disease runs about as follows : The slight halt, which is at first present in the morning, after a greater or less period, becomes a decided limp which is not overcome by exercise. The child, in standing or walking, supports itself

principally on the sound limb with the offending one flexed at the hip and knee, with the ball and toes touching the floor, the flexion at the hip and knee acting as a spring to break the weight from the articular surfaces of the hip joint. At this stage pain may or may not be present.

During the early stage the child, when apparently sleeping comfortably, may utter a moan, or a scream, and on going to him you will probably find him sleeping as calmly as possible. Children are troubled with "night cries" generally in the fore-part of the night, although they may occur at any time. They are caused from irritation reflex to the inflammation of the joint. One scream or six or eight may be given in succession, these, in a few moments followed by others, or no more may occur during the night. Some authors state as the average number of screams during the night one to twelve or fourteen, but I can call to mind two or three in whom their "night cries" averaged from ten to thirty-odd. This is a very important point in diagnosis. Generally the "night cries" come a little later than lameness and pain. Pain is a very uncertain symptom. Some cases are excessively painful, so much so that the child will scream, as though he were being murdered, on the slightest manipulation of the joint; while the next case may run its entire course without causing any annoyance from pain.

Muscular fixation is a very early accompaniment, due to the *reflex action* on the muscles controlling the joint. Upon this the most dependence in diagnosis is to be placed. All the motions of the thigh are either absolutely fixed or restricted; some motions may be more limited than others, for instance extension and abduction may be very slight, while flexion remains quite free.

Too much importance cannot be put to this muscular fixation, for in it we have an absolute key, we may say, to the progress of the disease, and also to it is due the malposition assumed, and from pressure of the head against the acetabulum, the wearing away of that bone and the head of the femur; hence we can readily see how this muscular rigidity is responsible for the awkward bony malpositions assumed in a bad, neg-

lected case. The muscles becoming contracted and rigid crowd the head of the femur against the wall of the acetabulum. This constant pressure causes a "wearing away" of the articular surfaces, and further allows union to take place between the denuded and impacted surfaces; the patient recovering with an ankylosed limb in whatever position the head may have been held. The malpositions are flexion, abduction, adduction and rotation. While neither abduction nor adduction are characteristic of any particular stage, abduction is probably more common early in the disease, adduction later; though many cases begin and end with adduction. The limb may and generally does assume a combination of two or more of these; for instance flexion may occur combined with abduction and rotation or adduction and rotation. When ankylosis takes place in a case of double hip disease with even very slight malposition, progression is necessarily very awkward and labored. When both limbs are adducted and ankylosis has occurred, "cross-leg" progression, from inability to separate the limbs, renders one almost entirely incapacitated for locomotion. In assuming the erect position, abduction and adduction cause tilting of the pelvis, producing characteristic postures more easily recognized than described; while flexion causes lordosis in the lumbar spine in standing with the legs parallel; by resting on the well limb, or lying on the back with the diseased limb flexed, the lordosis may be overcome.

*Shortening*, an almost invariable accompaniment of hip disease, is largely due to *muscular contraction*. The pressure upon the diseased head conduces to a destruction of the articular surface and an alteration in the shape of the head and neck, allowing the trochanter to ascend above "Nelaton's line." When the acetabulum becomes diseased, a curious enlargement is apt to take place. The irritated muscles crowd the head against the upper border of the acetabulum, which produces an absorption of that portion of the rim resulting in an actual enlargement of the "acetabulum cavity" from below upwards, and the femur following, a pseudo-luxation is the result. Besides the shortening produced by destruction of bone in the femur and acetabulum, there is a decided trophic disturbance which results in re-

tarding the bony growth and, at the same time, probably produces a certain amount of bone atrophy in extreme cases.

The shortening of the affected limb exists principally in the femur, although the tibia may share in it to a less extent also. The shortening of the thigh is generally about two-thirds of the whole, it may be less or again represent the whole amount.

Shaffer and Lovett claim, from an analysis of twenty-five cases of cured hip-disease, that the difference in the length of the legs almost always increases slightly after the disease is cured.

This leads us to another and *very early* and decided symptom of hip-disease, namely, muscular atrophy. This is claimed by some to be reflex to the diseased joint, by others to disuse. As this presents itself at such an early stage of the disease and before immobilization or rest of the affected limb could possibly have any effect in producing the amount of atrophy existing, it appears to the writer nothing more than rational that we should look to some nervous origin for this condition; to some trophic change produced by a reflex from the diseased joint.

In support of this, "if the muscles of the thigh are tested for contractility to the irritation to the faradic current it will be found that the contractility is markedly diminished."—(Bradford and Lovett.)

Atrophy of the muscles is an invariable accompaniment of a diseased joint and may begin quite early and proceed very rapidly, or it may be absent for weeks or months; though in my fourteen months' experience at the hospital for Ruptured and Crippled, New York, I cannot recall a case in which there was no atrophy, even on the first examination.

The writer realizes the fact that in most dispensary cases the disease may have existed for weeks or months before surgical advice is sought; while in private practice one has far better opportunity for seeing these cases at their invasion.

The inguinal glands frequently become enlarged, and occasionally to such an extent as to impede the venous return. They are occasionally the seat of superficial abscess. In very severe cases the tissues in the hip, the peri-articular tissues, become

œdematous, this may disappear or result in the formation of an abscess.

In a large proportion of cases suppuration takes place and is frequently accompanied by very severe pain. Abscesses may be peri-articular or articular according as the initial focus of the epiphysis extends outside of or into the joint, or an abscess, originally peri-articular, may later involve the joint. The formation of an abscess is frequently without constitutional symptoms although it may be accompanied by slight fever. After the pus has left the joint cavity, it burrows through the thigh muscled to reach the surface, where it appears as a fluctuating tumor of varying size. After having reached the skin, the same becomes red, glazed, thin and ulcerates at one or more points, allowing spontaneous evacuation. The abscess may terminate with its evacuation, but far more frequently continue to discharge from a fistulous opening for months or years. The pus may dissect through the tissues and point at the anterior border of the tensor vaginæ femoris, or back of the great trochanter or lower border of the gluteus maximus, or on the inside of the thigh in front of the adductor tendons; it may descend and open in the popliteal space or ascend in the sheath of the psoas and discharge above Poupart's ligament, or it may discharge into the rectum. Improper treatment, malposition, firm muscular fixation and a painful condition of the joint conduce, it has been claimed, to the formation of abscess.

Out of three to four hundred cases of hip disease treated by ambulatory methods at the Out Door Department of the Children's Hospital, Boston, only thirteen reported as having developed abscess. (B. and L.) There, as soon as malposition becomes marked, the patient is admitted to the hospital, and an attempt is made by rest and gradual extension to overcome the deformity. When this has been accomplished the patient is again allowed to get up and go about as usual with splint adjusted.

The general condition may remain good throughout the entire course of the disease, or the child being in apparently robust health at the beginning, after a few months becomes pale and the appetite capricious, anorexia following, the patient losing



flesh and strength; at this stage it may stop; the appetite being regained, improvement in the general condition following; "but at other times decided constitutional disturbance" may supervene.

Very few cases of hip disease run a smooth even course; *i. e.*, they will for some time run without an untoward symptom, and then without any apparent cause an exacerbation will occur, soon followed by a remission and so on; or the case may be characterized by its extreme severity, when as suddenly a remission in these severe symptoms will occur, only to be followed soon with probably increased severity.

#### DIAGNOSIS.

The diagnosis of hip disease rests upon the following symptoms: 1, stiffness; 2, lameness; 3, atrophy; 4, pain; 5, malpositions; 6, swelling. The chief diagnostic sign in hip disease is muscular rigidity, "*the presence of stiffness of the joint or limitation of its proper arc of motion*, when the limb is passively manipulated." There can be no disease, except probably in its very incipency, without limitation of motion. This is not due to adhesions, but to a tonic spasm of the muscles controlling the joint, and disappears under an anæsthetic.

At times great care and skill are required to detect slight limitation of motion, *especially in young children*, who are apt to become frightened and resist any attempt at examination. When due to fright, however, resistance is made to all motions of the limb, and to both limbs alike; should this be overcome, or should the child's attention be withdrawn from its limb, then resistance to rotation of a flexed thigh and to the *extremes* of the normal motions *will not* be encountered; whereas, in hip disease it is at the *extremes* of the arc of normal movement that *resistance is experienced*. Valuable information can be obtained from a comparison of the movements of the two limbs.

Flexion may be determined by flexing the sound limb upon the abdomen to its utmost limit, then repeating this with the suspected limb, keeping the sound limb firmly on the table. By repeating the flexion of the sound limb and extending the other until the pelvis begins to move, the degree of extension may be

obtained. Extension may also be determined by placing the two limbs parallel so that the popliteal space of both will rest against the table; normally there will be no change in the back, but should there be contraction of the psoas and iliacus, the back will be arched as the diseased limb is pressed down. Extension and hyper-extension may be determined by examining the patient lying upon the belly. With one hand placed firmly upon the sacrum, with the other alternately raising the thighs from the table, any difference in the amount of extension can readily be detected.

Abduction and adduction can be determined, the patient lying upon his back, by firmly grasping the anterior superior spine of the ilium, on the sound side, with one hand, and with the other adduct and abduct to the extreme limit of the suspected limb; this should then be repeated on the sound limb. In the early stages limitation to rotation is not so easily detected. It is determined though as follows: Flex the thigh on the abdomen, then rotate the femur and abduct. This will frequently show a limitation as compared with the sound side.

Limp is another early symptom of considerable value. In fact, hip disease cannot exist without giving rise to it, but, as stated above, in the early stage it may be intermittent, or barely perceptible.

It is worse in the morning than at night. Muscular atrophy occurs very early. Its absence, however, does not necessarily exclude hip disease. The obliteration of the folds and creases of the haunch, and the flabby and sunken appearance of the buttock, are largely due to this atrophy.

Atrophy may be determined by inspection, if it be decided, or by palpation, the muscles giving a soft and flabby feel, or with the tape. Accuracy is always preferable, hence the circumference of both limbs is taken at corresponding distances from some bony prominence, as the anterior superior spine of the ilium, the patella or malleolus. The circumference of thigh, knee and calf should be taken. The thigh will give from one-fourth of an inch to an inch of difference, the knee very little if any, while the calf will be about half that of the thigh.

The location of pain, as well as its intensity, is variable, but it is most frequently referred to the inside and front of the thigh, near the knee, or to the knee joint solely.

The intimate anastomoses of the sciatic obturator and anterior crural nerves are thought by many to offer the best explanation of this. Occasionally the pain extends into the leg, following the course of the sciatic nerve. Pain referred to the hip is indicative of suppuration, or due to nervous hyperæsthesia. Tenderness on percussion of the joint is neither an early or constant symptom. Percussion, as an aid to diagnosis, is an unjustifiable procedure, as the information gained will not begin to compensate for the damage done in jamming the head of the femur against the acetabulum.

Swelling is not very common in the early stage unless the disease has been unusually severe and rapid. In the later stages œdema may become quite a prominent feature. The inguinal glands may become enlarged and suppurate on one or both sides.

The abnormal positions, due to muscular contraction and bony ankylosis, are abduction, adduction, flexion and rotation, or there may be two or more combined. Abduction or adduction may exist to a marked degree and still not be recognized by the patients as such, they attributing the difficulty of locomotion to lengthening or shortening of the diseased limb. The trouble really lies in the tilting of the pelvis, which causes the limb to appear shorter if adducted, longer when abducted. This is termed the practical shortening or lengthening and may be measured by taking the distance from the umbilicus to the malleoli. The tilting of the pelvis may be recognized by mere inspection or by placing a tape from one ant. sup. spine of the ilium to the other, which should be at right angles to a second line or tape placed from the umbilicus to the symphysis pubis. Real or bone shortening results from retarded growth, or from the destruction of bone in the joints. The amount of destruction which has been done to the head of the femur and acetabulum may be estimated by determining the amount of subluxation. The patient lying upon the well side with the affected thigh slightly flexed, "Nelaton's line" is drawn over the dis-

eased hip, *i. e.*, a line drawn from the ant. sup. spine to the most prominent part of the tuberosity of the ischium should pass just above the upper margin of the trochanter major. Should this be above the line it is evidence of so much subluxation.

The real shortening or lengthening is determined by taking the distance from the ant. sup. spine to the corresponding malleolus. The amount of abduction and adduction was formerly and is still to some extent taken by means of the goniometer; this not being always at hand and frequently inaccurate, a method has been devised by which it is possible to estimate the angle of deformity with the tape measure and a table of figures.

The real and apparent lengths of both limbs are taken. The difference between the differences in the two kinds of shortening is noted. The only other measurement required is that between the ant. sup. spine. This obtained, turning to the table, we follow the line which represents the difference in inches between the apparent and real shortening, until it intersects the line, giving the pelvic breadth, when we have the degree of either abduction or adduction.

*"If the practical shortening is greater than the real shortening, the diseased leg is adducted; if less than real shortening, it is abducted."*

For example, the real length of the right limb being 26 inches, left limb 25, apparent length of right limb  $28\frac{1}{2}$ , left limb 26 inches; difference in real shortening 1 inch; apparent shortening  $2\frac{1}{2}$  inches, hence the difference between the differences is  $1\frac{1}{2}$  inches; pelvic breadth, 8 inches. Now, if we follow the line for  $1\frac{1}{2}$  inches, until it intersects the pelvic measurement of 8 inches, we find 11, which means  $11^{\circ}$  of abduction of the diseased thigh.

## DISTANCE BETWEEN ANT. SUP. SPINE IN INCHES.

		3	3½	4	4½	5	5½	6	6½	7	7½	8	8½	9	9½	10	11	12	13
		Deg.	Deg.	Deg.	Deg.	Deg.	Deg.	Deg.	Deg.	Deg.	Deg.	Deg.	Deg.	Deg.	Deg.	Deg.	Deg.	Deg.	Deg.
Difference in inches between real and apparent shortening.	1	5	4	4	3	3	2	2	2	2	2	2	2	2	1	1	1	1	1
	1½	10	8	7	6	5	5	4	4	4	4	4	4	4	3	3	3	3	2
	2	14	12	11	10	8	8	7	7	6	6	5	5	5	4	4	4	3	3
	2½	19	17	14	13	11	10	9	9	8	7	7	6	6	5	5	5	4	4
	3	25	21	18	16	14	13	12	11	10	9	9	8	8	7	7	7	6	6
	3½	30	25	22	19	17	15	14	13	12	11	10	10	9	9	9	8	7	7
	4	36	30	26	23	20	18	17	15	14	13	13	12	11	10	10	9	8	8
	4½	42	35	30	26	23	21	19	18	16	15	14	14	13	12	12	10	9	9
	5		40	34	30	26	24	21	20	19	17	16	15	14	13	12	11	10	10
	5½			39	34	29	27	24	22	21	19	18	17	16	15	14	13	12	11
	6				38	32	29	27	25	23	21	20	19	18	17	16	14	13	12
	6½				42	35	32	29	27	25	23	22	21	19	18	16	14	13	12
	7					39	36	32	30	27	26	25	22	21	20	19	17	15	14
	7½						40	35	33	30	28	26	24	23	22	21	19	17	16
	8							38	35	32	30	28	26	25	23	22	20	18	17
	8½							42	38	35	32	30	28	26	25	23	21	19	18

A somewhat similar method may be used for measuring the degree of flexion. "The patient lies upon a table, flat upon his back, and the surgeon flexes the diseased leg, raising it by the foot until the lumbar vertebræ touch the table, showing that the pelvis is in the right position. The leg is then held for a minute at that angle, the knee being extended, while the surgeon measures off two feet on the outside of the leg with a tape measure, one end of which is held on the table so that the tape measure follows the line of the leg. From this point, on the leg, where the two feet reaches by the tape measure, one measures perpendicularly to the table and the number of inches (in the perpendicular line) can be read as degrees of flexion of the thigh by consulting the following table. For instance, if the distance between the point on the leg and the table is  $12\frac{1}{2}$  inches, it represents  $31^\circ$  of flexion deformity of the thigh."

Inches. Degrees.	Inches. Degrees.	Inches. Degrees.	Inches. Degrees.
0.5..... 1	6.5.....16	12.5.....31	18.5.....51
1.0..... 2	7.0.....17	13.0.....33	19.0.....52
1.5..... 3	7.5.....19	13.5.....34	19.5.....54
2.0..... 4	8.0.....20	14.0.....36	20.0.....56
2.5..... 6	8.5.....21	14.5.....37	20.5.....58
3.0..... 7	9.0.....22	15.0.....39	21.0.....60
3.5..... 9	9.5.....24	15.5.....40	21.5.....63
4.0.....10	10.0.....25	16.0.....42	22.0.....67
4.5.....11	10.5.....27	16.5.....43	22.5.....70
5.0.....12	11.0.....28	17.5.....45	23.0.....75
5.5.....14	11.5.....29	17.5.....47	23.5.....80
6.0.....15	12.0.....39	18.0.....48	24.0.....90

The writer has had no personal experience with this method of determining flexion, having depended entirely upon Thomas' tests and the goniometer, although he is satisfied that at times it may prove very valuable.

The patient lying upon the back, the sound limb is flexed on the abdomen and held firmly; at the same time the diseased limb is extended to the extreme limit, care being taken to keep the lumbar spine in contact with the table. In this position one arm of the goniometer is placed along the axis of the thigh, the other on the side of the body, so that the upper end points to the center of the axilla. The degree of flexion is then read off the scale, which, in this position, will be over the trochanter major.

*(Concluded next issue.)*

## ONE HUNDRED CONSECUTIVE CASES OF SKIN DISEASE.

### IV.

By M. B. HUTCHINS, M. D.,  
Lecturer on Diseases of the Skin, Atlanta Medical College.

#### SEBORRHOIC ECZEMA.

In the March, 1889, number of THE JOURNAL I gave an abstract of the description, by Unna, of Hamburg, of this disease, the title being originated by him. It is therefore only necessary

to refer the reader to that description and thus save repetition. Unna's view does not now appear to have been so generally adopted by dermatologists as was expected at that time, but no matter what we call the condition, the fact remains that Unna's treatment is good enough, if not the best, for it.

The first case which I saw in Atlanta was that of an infant aged four months. Old seborrhœa, closely adherent flakes of dirty, greasy, though rather dry, sebaceous matter on scalp, with thickening, redness and scaling of skin of temples and cheeks; fissuring behind ears and slightly on other diseased parts. The parents believed the disease would be *driven back into the blood* by local treatment, and as that treatment was chiefly indicated, I did nothing for the case.

Manifestations of this disease varied from simple dandruff, with a few reddened, scaly points, with itching when warm, to large patches on scalp and other parts, sero-crusts and discharging. The majority corresponded to the condition yet generally described as seborrhœa of the type "*oleosa*;" greasy scales on scalp and an oily condition of face, especially of nose and naso-labial furrows and forehead.

A typical case of eczema seborrhoicum was that of a physician living out of the city, age thirty-five. Disease present several years. Greasy scales and flakes on scalp. Frontal baldness, progressing towards vertex. Entire skin oily, and patient perspired freely. A few faintly red patches on scalp and face. Redness and formation of greasy scales in eyebrows (which had become thin), mustache and beard. Scales, many of them, loose and occupying hairs above the skin. From clavicles to level of nipples (chest very hairy) gyrate patches of redness, sharply defined by normal skin; no thickening, a slight disquamation of greasy scales. Similar condition, modified by moisture of parts, in scroto-femoral region. Some itching in diseased skin. Got well under—

R. Resorcin, ʒi-ʒi.

Sp. vini rect.,

Aquæ, aa. ʒii.

M. Sig.—Apply thoroughly morning and night ; at night following with—

R. Resorcin, gr. xv.  
Ungt. zinc oxid.,  $\xi$ i.

M. Sig.—Rub well in.

The age of these patients varied from four months to forty-five years. Majority of the patients, thirteen in all, were males, seeming to indicate that the trouble is more common in this sex. But I do not think the figures would furnish reliable statistics upon this subject.

Health of the patients, as a rule, was not “bad,” but it is a disease most likely to occur in persons a little “run down.”

At the risk of being called empirical, perhaps justly, I confess that I have “stuck to” the resorcin, average three per cent., in lotion and ointment, beginning the treatment of the scalp with a thorough cleansing with plain soap and water, repeating this once or twice per week. Two months’ treatment, average, should cure most cases, but of course the dandruff may return some day under the influence of conditions of the system which lower vitality. As preventive of return, the following, applied occasionally, will be found useful:

R. Resorcin, gr. xv.  
Lanolin pulv., gr. x.  
Sp. vini rect.,  
Aquæ, aa.  $\xi$ ss.

M.

In the above the lanolin, partially in solution, prevents the hair and scalp from being left in too dry condition.

16½ *Whitehall St.*

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The legislature of Texas has now under consideration a bill to regulate the practice of medicine, and to create a board of medical examiners in Texas, and the probability seems to be that the measure will pass. This is at the instance of the Committee on Legislation of the State Medical Association, and we congratulate our brethren of the Lone Star State.



## Society Reports.

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### THE CLINICAL SOCIETY OF LOUISVILLE.

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Stated meeting, January 13, 1891.

THOS. P. SATTERWHITE, M. D., President, in the chair.

DR. L. S. MCMURTRY presented a specimen from a case of extra-uterine pregnancy, with the following history:

MRS. S. E. M., aged twenty-seven years, married nine years. Eight years ago she suffered an abortion at three months, has had uterine disease ever since, and has been sterile. She missed the menstrual period in November, and on December 7th called to see her physician, Dr. George W. Griffiths. Her complaints were of general abdominal pain and discomfort. She again called on Dr. Griffiths on December the 11th. On the 13th, two days later, she had a violent paroxysm of pelvic pain localized on the right side. Dr. Griffiths saw her soon afterward and administered a dose of morphia. She was relieved for the time. On the evening of the 18th Dr. Griffiths summoned me to meet him in consultation, and expressed the belief that abdominal section was indicated. The abdomen was swollen and tender with increasing peritonitis. There was a bloody flow from the uterus. The patient was pallid as from *post-partum* hemorrhage. Vaginal examination showed the uterus pushed to the left side and the pelvis choked with effusion. The pulse was 134, small, the pulse of hemorrhage. The bowels had not acted in four days. We gave an energetic purgative, and arranged for operation the following morning.

Early on the morning of the 19th I opened the abdomen. Dr. J. W. Guest gave ether and Dr. Griffiths assisting. On opening the peritoneum a large quantity of blood flowed out over the table. More than a gallon of blood-clot was removed. The fetal ball was on the right side. The right appendage was

tied off close to the uterus, the cavity irrigated with warm distilled water, a glass drainage tube placed, and the abdomen closed. When put on the table the pulse was 140 and quite feeble. The appendage on the opposite side was not removed, as I feared to prolong the operation. The operation was concluded in thirty minutes.

The specimen is of great interest. You will recognize here the ovary, and here the ruptured fallopian tube and the fetal envelopes. From this poured the fearful hemorrhage, which invariably ends in death if not arrested by surgical interference.

This is the first case of extra-uterine pregnancy, so far as I can learn, operated upon in Louisville by abdominal section at the time of rupture. The success of the case is due to Dr. Griffiths' recognition of the gravity of the situation, and advice for immediate operation.

Ectopic gestation is a very common accident. Hundreds of women perish annually from this cause because it is not recognized. Dr. Formad, the well-known pathologist of the University of Pennsylvania, as coroner's physician for Philadelphia, states that in one year he found *post mortem* nineteen cases of ruptured ectopic pregnancy unrecognized. The symptoms are those of shock, internal hemorrhage and peritonitis. The patients exhibit a history of sterility and peri-uterine inflammation. The fertilization of the ovum in the fallopian tube is due to a desquamated salpingitis by which the lining of the tube is deprived of its ciliary epithelium. Extra-uterine pregnancy is almost invariably tubal. The tube ruptures about the twelfth week. It may rupture through the free surface of the periphery of the tube directly into the peritoneum, as in the specimen here presented. This is a deadly accident, if the hemorrhage is not arrested by surgical means. The rupture may occur in the portion of the tube included between the folds of the broad ligament, allowing the fetal structures to escape into the cavity of the broad ligament. These latter are the cases of extra-uterine pregnancy which go on to a viable period. Extra-uterine pregnancy until very recently was not understood in its pathology, and was classified and treated as accidental hemorrhage, hemat-

ocele, etc. It is now well known that most cases of hematocele so-called are in reality cases of ectopic pregnancy. The treatment in all cases should be immediate abdominal section. The uterine appendages of both sides should be removed, inasmuch as the predisposing salpingitis is symmetrical. I have now operated in three cases within the last two years for ruptured tubal pregnancy, and all have recovered. The only safety in such a condition is immediate operation. The diagnosis before rupture is practically impossible. When rupture occurs the indications for surgical interference are as positive as in treating a wound of the brachial artery.

DR. GEO. W. GRIFFITHS: I can add very little to the history as already detailed. As soon as the symptoms of shock and hemorrhage appeared I advised operation. I have witnessed a great many bloody operations, and in my work as a railroad surgeon have seen many severe accidents, but I must say that when the abdomen was opened in this case and the blood gushed out it was the most formidable operation I have ever seen. I saw the patient to-day and she is entirely healed and well, though she is pale from the severe loss of blood. She went to the table and ate with the family to-day for the first time, three weeks after the operation.

DR. I. N. BLOOM: Had the symptoms been more pronounced the night you first saw her would you not have operated immediately?

DR. McMURTRY: Operation would have been immediately done had the diagnosis been absolutely positive. That is, of course, impossible before the abdomen is opened.

DR. J. A. OUCHTERLONY: I do not know when I have seen a specimen and heard a report so interesting and of such great practical importance as this. It brings vividly to my mind a number of cases I have seen during the past thirty years, which were diagnosticated by myself and others with whom I was associated as pelvic hematocele, and at the same time there was always something inadequate in the diagnosis, and it seemed incomprehensible why there should be such terrific hemorrhage and such

profound shock. It is a great satisfaction to know that light has been shed upon this important and perilous condition, and that we can predicate accurately the pathological condition. Cases that formerly were considered to be cases of hematocele are now known to be ruptured ectopic pregnancy. A most pleasant reflection is the fact that these cases can be so successfully managed by prompt surgical interference. It gives confidence and hope to the medical attendant, and it is a warning, and a solemn one, to lose no time in adopting the prompt course of procedure taken in the case just reported.

**DR. F. LEBER:** Many cases of hematocele recover by absorption, without operative interference.

**DR. McMURTRY:** When rupture occurs through the free surface of the tube it is a deadly accident from hemorrhage, unless treated by surgical means. If the rupture, however, takes place into the folds of the broad ligament the effusion may become absorbed, or the fetus may develop there, forming abdominal pregnancy and going on to and beyond full term. The fetal mass may break down and suppurate, discharging through the rectum or the bladder. In any contingency the safest result is secured by abdominal section. There is less danger in abdominal section according to modern methods than by taking the risk of these several terminations.

**DR. T. P. SATTERWHITE:** It is the first specimen of the kind I have ever seen. I agree with the essayist that it is an exceedingly difficult matter to diagnose absolutely that condition of things. In several cases, which I have seen with Dr. McMurtry, I considered his advice to open the abdomen unwise, but in every instance have been convinced that it was the correct course to pursue.

#### CRUSHED FOOT.

**DR. F. LEBER:** I was asked to see a young man who was injured out West. It was a case of crushed foot. When he arrived at his home in Louisville he had been treated for three weeks. The foot was in a very bad condition, and I advised amputation above the ankle-joint. This was refused, and the

case was treated by another physician. I was again asked to see him, and again suggested amputation, which was refused. I report this case to say that in my opinion in all such cases amputation should be done above the ankle-joint. In my opinion Chopart's amputation has never been satisfactory. I recall to mind a case left in my care by the late Dr. Cowling in which Chopart's amputation was done. It left a miserable pointed stump. I treated it for months with various devices, but never succeeded in getting a good stump. I was compelled finally to amputate. My experience during the war convinced me that none of these operations below the ankle gave such good results as amputating above the ankle.

DR. J. W. GUEST (by invitation): I had two cases of this description in the hospital. Both healed by primary union, and were discharged at the end of one month. It seems to me that in doing Chopart's amputation you save the ankle-joint as a natural joint, which is better than an artificial one. At each of these operations tenotomy was performed to prevent the stump from pointing. My experience with Chopart's amputation has confirmed that operation in my confidence. It gives a good, solid base for a foot independent of any artificial foot.

#### SWEATING OF FEET.

DR. I. N. BLOOM: I wish to make a report of a case, although one case does not determine the method of treatment for a given disease. I recently had a case of sweating of the feet. The means I employed in this case were very simple. I had the patient bathe the feet in a solution of bichloride of mercury, 1 to 1,000, morning and evening. After rubbing the surface carefully so as to remove the dead epidermis macerated by the sweat, I directed the following course, which is partly though not wholly original. I had a plaster sole, partly soaked in a bichloride solution, put in the shoe, the solution being 1 to 1,000. After drying the sole and placing it in the shoe, I sprinkled it with powdered boric acid. As regards the advantage of this method of treatment there is much diversity of opinion. In this case the result was quite satisfactory. If this treatment were uniformly success-

ful it would point to a micro-organismic origin for the disease rather than a neurological. My experience has been too short to determine, but this I know, that in many cases, especially of the lighter forms, it is of nervous origin. I have always found it much easier to cure simple hyperidrosis of the feet than the hands, and have found that Hebra's method with diachylon ointment is the only one promising any hopes of success. I have tried many other means recommended by worthy men, but always had to return to the diachylon. The inconvenience of this latter method is great, but patients bear it, or will bear any treatment that will help to get rid of the disagreeable disease. This is especially true of women.

#### PHARYNGEAL FISTULA.

DR. WM. CHEATHAM: I have seen recently three cases of congenital pharyngeal fistula. They all opened on the left side of the larynx. Colored fluid, such as the methyl-violet solution, injected into the fistula, passes into the pharynx; a peculiar viscid fluid, with air bubbles, escapes when pressure is made on the tract. These cases are very difficult to heal, as the course of the fistula is so sinuous, and the healing must commence at the pharyngeal end. The best method to close them is by the galvano-cautery wire.

#### MEETING OF JANUARY 27, 1891.

DR. J. A. OUCHTERLONY exhibited a patient, with the following remarks: The history of the case is this. The young gentleman is about eighteen years of age. A year and a half ago he began to fail in health. He came under the treatment of a gentleman who regarded the case as one of asthma. The result was that he did not improve, but continued to grow worse. He was under this doctor probably three months. Then he fell into the hands of a very careful physician, who treated him awhile and did him a great deal of good. Still the disease went on. I do not know whether it was recognized by the second physician or not. Then he was under the Blair treatment for catarrh, and from the Blair establishment he came to me in the middle of October last.

I found him with somewhat quickened breathing and pulse, temperature slightly elevated at midday, and unmistakable evidence of consolidation and incipient softening. He had lost flesh very considerably, coughed a good deal, had night sweats occasionally, and in the afternoon his hands became hot and burning. I had my friend, Mr. J. A. Flexner, examine his sputum, and found it loaded with tubercle bacilli.

While abroad this summer, I came across an article written by Dr. O. Tostensen, in Sweden, who devotes himself to the treatment of pulmonary affections. He announces that for the last two years he had been in the habit of using subcutaneous injections in cases of tuberculosis. He employed a five-gram injection, also a smaller one of one gram. When he made use of the five gram, he would make injections every other day or twice a week; but when he used one-half that size he resorted to injections every day or every other day. He always used the injection between the shoulders and on the sides, and always injected the fluid deep, not in the thickness of the skin, but would pinch up the skin and throw it right into the subcutaneous cellular tissue. A little pain is occasioned, and often some redness and swelling, but if the syringe is kept well disinfected, no abscesses follow. The formula used is the following:

Acidium carbolicum niveum . . . . .	10
Menthol . . . . .	5
Vaselinum liquidum . . . . .	} aa. 20
Oleum olivarum steriliz . . . . .	
Sol. bals. Peruv. 20 in petroleum benzinum, 10.	

M. S.: One-half to a five-gram syringe-ful two to three times a week.

Now I began to use this solution, and although I have made some forty injections in this case I have never had a single abscess. It has been painful, but the swelling would pass away and the pain still more quickly. I have gone all around the chest. Under this treatment fever disappeared, pulse and breathing became slower, and eight pounds were gained in flesh. I regret very much to say that I have not had time to have the sputum

examined to-day, but shall have it done very speedily and will report progress to the Society.

We have used the treatment at the University clinic, but without very marked results; because patients would not come regularly, and they were of a class whose hygienic surroundings were exceedingly poor.

The young gentleman recently went through an attack of acute bronchitis, undoubtedly due to taking cold, and recovered without any difficulty as readily as if it had occurred in a person entirely free from tuberculosis. The dullness has diminished in extent and degree, and pain in the chest has disappeared. No râles can be heard at present. The only internal medication he had was arsenious acid gr. 1.30 three times daily.

DR. W. H. WATHEN: At Johns Hopkins Hospital recently, where they were using the Koch lymph, I noticed that after each injection in a very short while the temperature ran up to 103° and 104°, showing marked general reaction from the use of it. They had the sphygmographic tracings that showed exactly how it affected the heart's action. This effect was so marked that it demonstrated positively that the lymph ought not to be used in any patient except under close observation.

DR. L. S. McMURTRY: I think the report is very interesting and instructive, particularly at this time. As I understand it, it is really a constitutional treatment of tuberculosis. The injections, I presume, are introduced with a view to their being absorbed by the blood, and having an elective effect upon tubercle bacilli. And at this particular time, when the attention of the whole world is being turned to that method of treatment, it is particularly interesting. It indicates that there are many lines of treatment which most probably will lead to the same objective point, and shows, too, that we have yet to learn much before we get to the conclusion about these grades of treatment.

DR. WM. CHEATHAM: It seems to me that it is a step in the right direction. That we will have to get some substitute for the Koch treatment, on account of the unfavorable reports made of it.



DR. F. LEBER : The report was exceedingly interesting, but in my opinion was incomplete, as a correct statement ought to have been made of the condition of the sputum from week to week, as to the number of tubercle bacilli present. Sorry he did not have it done. Would like to have had the last slide compared with the original slide. The question is, was the benefit derived due to the arsenious acid or the subcutaneous injections? We have all had cases where patients have improved in the incipient state from general treatment without injections of any kind. It was supposed by the best bacteriologists that Koch's lymph was nothing but an extract of the natural tubercle itself, which it turned out to be.

DR. PETER GUNTERMANN : The report, as far as Dr. Ouchterlony has made it, is very instructive. The report as to the number of bacilli ought to have been given. I was at his office when he made several injections, and it was remarkable that there was not a sign left where former injections had been made.

DR. L. S. McMURTRY : I here present for examination by the Fellows a very large submucous uterine fibroid tumor which I removed a few days since. It is the largest tumor of this class I have ever encountered, being quite as large as a child's head at full term. The tumor had been expelled from the uterine cavity and occupied the vagina, with severe distention and pressure on adjacent organs. The pedicle was very large and was intra-uterine. The lady was thirty-eight years of age. By continuous hemorrhage she was greatly reduced and exsanguinated.

In consequence of the immensity of the tumor I was compelled to remove it by sections, instead of *en masse*, in order to avoid tearing the perineum. I placed the wire of a *serreneude* around the pedicle and cut away the tumor. My friends, Drs. Griffiths and Vance, were present at the operation, and the former suggested division of the pedicle by the wire at one sitting, but I was afraid to do so. On the day after the operation, in tightening the wire, it broke, and a fearful hemorrhage resulted. The hemorrhage was very fierce and its effect was immediate upon the patient's expression. Seizing her as she lay in bed, I placed

her on a table, retracted the perineum with Sim's speculum, and clamped the bleeding pedicle. Within a minute's time the bed and floor were saturated with blood. It was like *post-partum* hemorrhage. The patient is making an easy recovery.

I report the case, not only on account of the magnitude of the tumor, but particularly to warn against the dangers of hemorrhage when treated as commonly directed by authors, viz., to divide the pedicle with the wire at one sitting.

DR. F. LEBER: I have a specimen of a tumor of this kind in my possession, removed several years ago, which is larger than the one just presented. I was called to the patient by a medical friend, and found the tumor in the vagina. I believe these tumors are expelled from the uterus when comparatively small, and grow to large size in the vagina. I do not believe the danger from hemorrhage is so great as the injury to the womb. Very often a segment of the uterine tissue is included in the *ecraseur* and injury done in that way.

DR. J. M. MATHEWS: It has occurred to me that we meet with these polyps in the rectum. In the last two or three weeks I have removed two, but the largest I have removed was about the size of a hen's egg. The other was a soft polyp about half that size. It comes into my mind, why is it we do not have larger polyps in the rectum. The capacity is very great, and it is the same class of fibrous polyp, but they are not often met with larger than I have mentioned. Hemorrhage is the danger in polyps of the rectum, especially where the pedicle sloughs.

DR. GUNTERMANN: Last fall a year ago, when on my regular visit to the country, I met a woman who had been a patient of mine when I was practicing in the country. She had been and was under the treatment of several physicians, who had examined her, but she was bleeding all day, and every day, and had been for a year. She was near where I made my stay and requested me to see her, and on account of her having been an old patient I did so. On examination I found a little polypus about the size of a hen's egg, resting in the os. I could feel it very well. As I had no means of removing it, I requested her to

come to Louisville, or I would go down and remove it. In the meantime I gave her some fluid extract of ergot, which she took in teaspoonful doses two or three times a day. The first notice I had from her she sent me the polypus, which had come away of itself.

DR. T. P. SATTERWHITE: In all operations of this kind the physicians should be prepared for hemorrhage. I assisted Dr. Geo. W. Griffiths in removing one; after it was taken away with forceps, it was as large as a child's head. There was no hemorrhage following.

DR. CHEATHAM exhibited a specimen of polypus of the esophagus, with the following remarks: An old gentleman seventy-nine years of age came to see me, saying for twelve years he had had something growing in his throat. Three years ago in vomiting he ejected it, caught it in his teeth, and went to Dr. Yandell, who removed it. He came to me saying it had returned; I tried with my finger to vomit him, but failed. I then tried the horse-hair bougie, but failed to get the growth up. I endeavored to use the esophagoscope, but his neck was too stiff and I could not introduce it. Yesterday he came to the office with a lot of sulphate of zinc and a large twine cord, and wanted to take the zinc and vomit to eject the growth, and tie the cord around it. We gave him 25 grains of sulphate of zinc with warm water, but it failed to act promptly. I then gave him hypodermically apomorphia gr.  $\frac{1}{6}$ , which acted promptly, throwing the growth into the mouth where it was caught with a vulsellum. The wire of a Jarvis snare was passed over the vulsellum and growth, and pushed well down, so as to get as close as possible to the base of the polyp; it was cut off with but little difficulty. The polyp measured five inches in length, one inch in diameter, and was almost cylindrical. Close to where the wire cut through there was a considerable constriction. Mucous polyyps of the esophagus are very rare.

DR. L. S. McMURTRY: This report is exceedingly interesting. It is the first specimen of the kind I have ever seen. It illustrates incidentally what a valuable agent apomorphia is in securing prompt emesis. I would ask Dr. Cheatham his opinion as to the recurrence of this growth.

DR. WM. CHEATHAM: It is very apt to recur.

DR. W. H. WATHEN: About a month ago a lady from cen-

tral Kentucky consulted me about an enlargement of the abdomen. She had a large fibroid tumor of the uterus that had probably existed for several years, but had caused no serious trouble until fifteen months before I saw her. Since then she has had excessive hemorrhage at each menstrual period, has suffered greatly from pelvic pressure, and has lost twenty-five pounds in flesh. The indications justified hysterectomy to relieve symptoms and save life. As I expected to go east in a few days to stay two weeks with my medical friends in New York, Philadelphia and Baltimore, I requested her to return to the city upon receipt of a telegram from me. On the morning of the 16th of this month she came to St. Joseph's Infirmary in a hurry to have the operation performed, and on the afternoon of the 20th an hysterectomy was done, and the uterus with a ten-pound tumor removed. The operation was complete in thirty minutes. The broad ligaments were tied off, the pedicle was secured by the neude and pins, the abdomen carefully cleansed, and the peritoneum stitched to the pedicle or neck of the uterus. She had no shock, and no untoward symptoms, until about seventy-two hours, when her pulse became rapid and she could not retain anything in her stomach. Her pulse finally reached 150 per minute, but her temperature was never above 100°. In a hundred and ten hours she died, apparently from septic infection; but as she had comparatively no fever, death may have been caused by intestinal obstruction from paresis of the bowels. Cases of this sort have been reported where no cultures could be made from the peritoneum or its secretions. She could not retain salines, and I gave her one grain of calomel every hour, but neither gas nor fecal matter would pass. If death was caused by septic infection, the point I wish to especially emphasize is the difficulty in excluding septic matter in operations involving the peritoneum. This is the only case of septic infection I have had in my laparotomies in eighteen months, and the surrounding conditions were never apparently more favorable, and I have never been more careful. The instruments and sponges were carefully cleansed in boiled water, and neither my nurse nor myself had been exposed to septic influences. The untimely death of this woman has so impressed me with the necessity of absolute surgical cleanliness in laparotomy work, and of my moral and professional responsibility, that I have had prepared a room in an addition to one of our infirmaries for such operations, with all modern aseptic appliances and conveniences, such as plate-glass top-tables, porcelain-lined pans, sterilizer, etc.

## Correspondence.

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### OUR NEW YORK LETTER.

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NEW YORK, March 15, 1891.

During the past two years important changes have been made in the lunacy laws of this State, which cannot fail to interest medical men throughout the world, as it is said that these laws are now among the best ever enacted. It is impossible to do more than refer briefly to the main features of the changes mentioned, and to suggest to those especially interested in the subject that a further study would be found exceedingly profitable. Two years ago the legislature created a State Commission in Lunacy, provided for the extension of the State Hospital accommodations, and changed the corporate titles of the State institutions for the insane to that of State Hospital, thus recognizing and establishing the hospital idea. This was done in accordance with the principle assumed in this State a number of years ago, that all insane persons were to be regarded as under the special care and protection of the State. The Commission in Lunacy consists of three members. The medical member, who is the chairman, the law requires to be a physician who has been in active practice for ten years and who has had some experience in the management of a hospital for the insane; the second member is a lawyer, and the third a layman, presumably a business man. They are salaried officers paid by the State, and are allowed wide scope in all matters pertaining to the care of the insane. The Commission has been in existence about twenty months, and has already done much good work. An important part of it consisted in an inspection of the county institution for the care of the insane poor. Their report revealed such a scandalous condition of affairs, that the Legislature pursued the principle of State care of the insane still further in the passage of an act providing that all insane persons who were a public charge should be confined only in institutions supported by the State.

Thus all the insane in the State whether in public or private institutions are now under the supervision of the Commission in Lunacy, who have full authority to secure the best conditions for the safety and comfort of the patients, and the security and satisfaction of the public.

#### THE STUDY OF INEBRIETY.

A series of interesting meetings have been held here this winter by the newly organized Association for the Study of Inebriety. At the last meeting the question of etiology was considered. A paper was read by Dr. L. D. Mason, of Brooklyn. He believed that heredity was the most potent predisposing cause, maternal inebriety having the most decided influence. This might produce miscarriage, or the offspring might be idiots or imbeciles or the victims of some neurosis. The moderate drinker whose tissues were bathed every day in alcohol, although never getting drunk, might have just as baleful an influence on the offspring. Acquired inebriety should be separated entirely from the hereditary. Head injuries, neurasthenia, any condition producing unrest and insomnia, might be regarded as exciting causes. Alcohol was certainly a useful hypnotic in the insomnia produced by grief or worry, but it was decidedly dangerous. Dr. J. B. Mattison followed with a paper on narcotic inebriety from the use of opium, chloral or cocaine. He believed that most cases of this variety of inebriety were produced first by the prescriptions of physicians for the drugs referred to, principally in painful affections and insomnia. A demand was thus created which led the way to the habit. When cocaine was introduced it was claimed that a cure for opium addiction had been found. Many victims were led to employ it with this hope, but only to find themselves slaves of a new and worse master. In his experience the cocaine habit was much worse than that of opium or chloral. In discussing Dr. Mattison's paper, Dr. Mason agreed with the former regarding the danger arising from careless prescribing or continuance of narcotics, and he believed that the druggists were responsible for many cases from indiscriminate renewing of prescriptions which ought

not to be repeated except on direct orders from the physicians. He also denounced the many patent medicines which found such a ready sale, many of which were of a very dangerous character. He said that the association had tried unsuccessfully to have a law introduced compelling the manufacturers to print the formula on each bottle. Most, if not all the so-called "cures" for the opium and alcohol habits consisted of opium or alcohol.

#### DIPHTHERIA.

At the last meeting of the Academy Section on Pædiatrics, Prof. J. Lewis Smith read a paper on the contributions of 1890 to our knowledge of diphtheria. He stated that he had derived the material for his paper from several volumes of extracts from periodicals, which had been placed in his hands for the purpose of preparing the article on diphtheria for the next volume of *Sajous' Medical Annual*. He would confine himself on this occasion largely to the important question of etiology. It had been discovered through researches in the Pasteur Institute that the Klebs-Lefler bacillus, which was now regarded as the true micro-organism of diphtheria, secreted ptomaines which were the direct cause of the systemic infection resulting in the well known blood changes, the nephritis and the paralysis. It was believed that other micro-organisms were capable of producing a membranous or pseudo-diphtheritic exudation, but with this systemic infection did not occur. Such an exudation sometimes appeared in the early stages of scarlet fever. It showed no tendency to invade the larynx, and did not communicate diphtheria to other children. Occasionally, however, true diphtheria supervened as the scarlet fever was declining.

Some interesting observations had been made by Klein, regarding the manner in which diphtheria might be conveyed. He had noticed that cats were sometimes affected with a bronchopneumonia, which in some instances was followed by paralysis of the hind legs. On *post mortem* examination large white kidneys were discovered due to fatty degeneration. This disease of cats produced diphtheria in children. Cultures of the Klebs-Lefler bacillus were introduced into the trachea of cats, and sub-

sequently a *post mortem* examination revealed a membrane lining the bronchi and air-cells, and the large white kidneys before referred to. One interesting incident was related, in which a boy sick with diphtheria had vomited, and the family cat had licked at the vomited matter. The cat soon afterwards developed symptoms which were thought to resemble those of the boy. It was immediately killed, but not before it had mingled with a number of cats belonging to neighbors. Several of the cats subsequently became sick, and a child of a neighbor to whom one of them belonged developed diphtheria and died. It was known also that pigeons, turkeys and common barnyard fowls were subject to diphtheria, and communicated it to human beings.

Some observations had been made regarding the vitality of the bacillus. It had been found that a culture preserved for sixteen months had lost none of its virulence. There were several incidents illustrating the same point. In one case a girl had contracted diphtheria after examining the clothes worn by her mother two years before when she had died of the disease. They had been kept shut up in a trunk from that time. In another instance the brush used in the throat of a diphtheritic patient was kept rolled in paper four years. It was then applied to a simple sore throat, when diphtheria soon followed. In still another instance a cradle in which a child sick with diphtheria had lain was not used for two years. It was then thought to be safe and another child was allowed to sleep in it. The result was an attack of diphtheria.

In the discussion following, Dr. A. Seibert expressed the opinion that the division into true and pseudo-diphtheritic exudations was not proper, and could not be useful clinically. Dr. J. E. Winters had observed the point mentioned by Dr. Smith regarding the development of diphtheria in scarlet fever cases, and corroborated the statement that it usually developed as the fever was declining.

In closing, Dr. Smith remarked that his reading had disclosed that wherever there was an intelligent medical profession, some preparation of iron was used in the treatment of diphtheria, gen-



erally the tincture of the chloride. In Europe the solution of the perchloride was preferred by some. The use of potassium chlorate had been discarded in France, on account of its irritant affects, and tendency to produce nephritis. In Great Britain and America, its use had been discontinued by some, while those who still used it had reduced the dose to half a grain or a grain.

#### TUBERCULIN.

The title by which we are in future to know Koch's fluid is "Tuberculin." One does not hear it spoken of as frequently as formerly, and it has not yet been definitely settled what place it is to occupy in our armamentarium for the treatment of tuberculosis. I believe that the prevailing feeling here is one of disappointment. The more thoughtful, however, and those who have had long experience in the observation of tuberculosis, are inclined to give it an honorable position. Prof. Jacobi believes that it has done and can do more for tuberculosis than any other remedy except climate and surgical procedures. It has been used in a number of lupus cases at the Skin and Cancer Hospital, but no cures have yet been accomplished.

WM. L. RUSSELL.

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Dr. W. C. Bailey, of the Post-Graduate Medical School, New York, was in Atlanta on the 12th inst., and addressed the Society of Medicine on Koch's "parataloid," or "tuberculin." Dr. Bailey spoke confidently of this new remedy, and reported several apparent cures which he had observed in New York hospitals. He emphasized the fact, however, that every case of tuberculosis is by no means adapted to this method of treatment. Patients should be operated upon only after having undergone a careful physical and clinical examination extending over several days. Dr. Bailey thought the method valuable as a means of diagnosis.

## Editorial.

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### THE GEORGIA ASSOCIATION.

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We desire to call the attention of our readers to the letter of Secretary Moore which appears elsewhere in this issue. We would urge all members of the Association who can do so to attend the Augusta meeting and participate in its deliberations; and we would also urge all Georgia doctors not already members of the Association to go down and unite with it at once. It is not necessary for us to remark on the great good which is accomplished at these annual meetings.

We of the South are too often reproached with the fact that we do not possess that energy and activity which is manifested by our northern neighbors. This is true of southern doctors, as well as southern merchants and southern farmers. The medical societies of the North are numerous and well attended. Members are eager to record their experiences and discuss the experiences and reported cases of others. The advantages of this spirit are obvious; it blesses him that gives and him that takes. This same spirit should pervade the profession throughout the South. To some extent, at least, the cases] occurring in the practice of our northern brethren, which are observed carefully, reported and discussed, can be duplicated in the experience of our own practitioners, yet, as a rule, the only record that is made of them is their entry in the physician's visiting list.

The statement was made last fall in this city, at the Surgical and Gynecological Association, by Dr. Joseph Price, of Philadel-

phia, who is easily among the best of American surgeons, that some of our best surgery is being done by country doctors. It is safe to say that three-fourths of this work is never recorded.

Manifestly, the only way of arriving at a just conclusion regarding any given disease or condition is by comparing recorded experiences.

THE JOURNAL will be much gratified if the above remarks will stimulate some of its readers to give others the benefit of their observations. Certainly its columns are always open for the purposes indicated.

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### COMMENCEMENTS.

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The commencement exercises of the two medical colleges in this city were held last month. The thirty-ninth annual commencement of the Atlanta Medical College took place at the opera house, March 2d. The report of the Proctor, Dr. W. S. Kendrick, showed that the session just closed had been the most successful one in the history of the College. There had been present during the term 163 students, of whom 80 were graduating. The degrees upon these were conferred by Hon. N. J. Hammond, President of the Board of Trustees. Following are the honor men: First, Dr. J. A. Weaver; second, Dr. B. S. Burton; third, Dr. L. B. Bouchelle, Jr. Each of these gentlemen was the recipient of a handsome gold medal.

Prof. Chas. A. Lane, of Georgia, delivered a bright and entertaining address to the graduating class.

Dr. Frank Park, of LaGrange, a young man of marked ability, was the valedictorian of the class. Dr. W. R. Slack, of LaGrange, then presented Dr. Clarence Johnson with a beautiful gold-headed cane, as a mark of the esteem in which he was held by the class of '91.

The twelfth annual commencement of the Southern Medical College was held at DeGive's Opera House, March 4th. The Dean of the Faculty, Dr. Wm. Perrin Nicolson, presided. In his report, Dr. Nicolson said that the purpose of the founders, to make this a school whose tendency would be to elevate the standard of medical teaching in the South, was being carried out, and that the work of the session just closing was encouraging. There had been in attendance in the two departments (medical and dental) 207 students, 102 of whom were in the medical department.

The graduating class, 36 in number, were then presented with their diplomas by Dr. Thos. S. Powell, the President of the College. Mr. Chas. A. Read, of Atlanta, delivered an able and witty address to the graduates.

The valedictorian of the class was Dr. J. McDiarmid, of Georgia.

The prizes were awarded as follows : First, Dr. T. H. Fritts, Tenn.; second, Dr. D. C. Rumph, Texas; third, Dr. J. W. Price, Virginia. The demonstrator's prize, a handsome case of instruments, was given to Dr. J. McDiarmid.

The Southern College has now in contemplation the erection of a new college building, which will greatly enlarge its facilities for doing good work.

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## THE PRESENT STATUS OF KOCH'S METHOD.

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We have taken some pains to ascertain from the exchanges which come to our desk, both home and foreign, the general sentiment in the profession in regard to this, our latest remedy for tuberculosis. Although sufficient time has not yet elapsed to admit of definite conclusions, and although some experimenters seem to be much disappointed at the results, yet the outlook is

not discouraging. The situation is well stated by Dr. J. M. DaCosta (*Medical News*): It is premature to come to any general conclusions concerning so new a remedy. In cases of consumption in which softening has commenced the lymph is of very little use; in early cases amelioration takes place in the general condition. We cannot speak of it as a curative agent. It may be said that no case has yet been cured. In lupus and tubercular disease of the joints great good has already been accomplished. Morell Mackenzie thus states the case: I believe that Koch's fluid is an agent of the highest possible value for the detection of tubercle; a remedy of great potency for certain of the slighter manifestations of tuberculosis; a palliative for some of the distressing symptoms of the severe forms of the disease; and a deadly poison in advanced or unsuitable cases.

This much, which is all that we are warranted in saying at present, simply encourages us to hope.

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### "THE PRESENT POSITION OF ANTISEPTIC SURGERY."

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In August last, Sir Joseph Lister delivered an address at the Berlin International Congress on the above subject. A little later, that eccentric figure in modern surgery, Mr. Lawson Tait, published a criticism of the above address in the *British Medical Journal*, in which he denied the principles underlying the practice of antisepsis, and attacked the truth of the prevailing antiseptic methods.

His paper may be summed up in these words (his own): "Lister and his illogical disciples talk of the septic or antiseptic theory, where there is no theory about it at all, but an absolute and ludicrous logical error."

This attack has prompted Prof. White, of the University of Pennsylvania, to publish a defence of modern antisepsis (*Annals of Surgery*, January, 1891). We question if any defence were necessary. However, Prof. White presents facts and arguments which, we think, cannot be answered by the weak opposition. For example, in 1864, '65, '66, Prof. Lister's mortality in all operations was 45.7 per cent., largely from septic diseases. Now he begins his antiseptic methods, and in the next three years ('67, '68, '69) his mortality falls to 15 per cent. Still further improving his methods we find that from 1871 to 1877 in all surgical cases his mortality from septic disease was only 36 per cent. Again, compound fractures of leg and thigh under the old treatment had an average mortality of 40 to 50 per cent. After the introduction of antisepsis this fell to about 4 per cent.

Prof. White continues: Lister's work since he took his first prize in 1852 has been of a character to commend the respect and admiration of the scientific world. Prof. Louis Agassiz said years ago, and Prof. Joseph Leidy later, that his work had been of the highest order, and the appreciation of his labors by the best minds in our profession had been enthusiastic and almost universal. Nearly every great surgeon in the civilized world had put on record his admiration for Lister's teachings, his acceptance of the general principles involved, and his sense of almost personal obligation to the author of the antiseptic theory.

That Mr. Tait should speak of such a man as having "lived in the clouds of his spray for the last twelve years," as "wanting logic," making "illogical blunders," "falling away from his own faith," etc., and should boast of having "laughed at" and "ridiculed" him and his doctrines and disciples is evidence of his unfitness by temperament or training for the serious discussion of broad surgical principles. I am quite sure that the vast majority of general surgeons will be found to have no sympathy with his views or his manner of expressing them, and it is a relief to find that in his own special line there are operators of equal eminence who repudiate both.

OFFICE OF SECRETARY  
MEDICAL ASSOCIATION OF GEORGIA,  
MACON, GA., March 12, 1891.

*Editors Atlanta Medical and Surgical Journal:*

Please allow me to announce in your JOURNAL that the Medical Association of Georgia will hold its forty-second annual session in the city of Augusta, April 15th to 17th, inclusive.

A letter just received from the chairman of the Programme Committee assures me that there will be an attractive and interesting programme arranged for the occasion. The fact that the same committee who gave us such an interesting programme at Brunswick last year is engaged to arrange the programme for this year is a sufficient guarantee that we will have a pleasant and profitable meeting.

Dr. Foster, Chairman of the Programme Committee, writes me that the profession of Augusta have their arms and hearts wide open to give the Association a cordial welcome, and that the city will entertain her guests handsomely; that full and ample hotel accommodations can be had, and that they are very anxious to have a full attendance.

Reduced railroad rates have been secured on all the roads in Georgia upon the certificate plan. Be sure to obtain from the agent where the going ticket is purchased a certificate of such purchase to attend the meeting; and this certificate, when signed by the secretary of the meeting, will entitle the holder to return on one-third the usual fare. If ticket is bought at an intermediate station, at which through tickets to Augusta cannot be purchased, buy to Atlanta, Macon, Albany, Savannah, Athens or Americus, as may be most convenient, and repurchase to Augusta, taking certificates from both agents from whom tickets are secured. The certificates obtained at the above named points will be honored at Augusta, returning to the point at which it was secured; and the other certificate will be honored from thence to the starting point. These tickets good until the 20th, inclusive.

It is very desirable to make this the largest and most profitable session in the history of the Association, and the Association extends a cordial invitation to every graduate of a regular medical college in good standing, to attend the approaching meeting and become a member.

Respectfully and fraternally,  
K. P. MOORE, Sec'y.

# THE ATLANTA AND MEDICAL SURGICAL JOURNAL.

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## TO CONTRIBUTORS.

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## Original Communications.

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### THE REAL AND RELATIVE VALUE OF OUR RECENT ANTIPYRETICS.\*

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BY J. C. JOHNSON, M. D., ATLANTA, GA.,

Lecturer on Diseases of Children, Atlanta Medical College.

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Perhaps in no era of medicine, since it has attained the dignity of a science, have so many rival remedies sought recognition in materia medica as are now clamoring for use. Scarcely have the merits of one been adjudged, and its place in therapeutics assigned, before its successor, boasting superior virtues, is announced and accepted, only to meet a similar fate. Thus the list of remedies lengthens, but to prove the narrow range of applica-

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\*Read before the Atlanta Society of Medicine.



tion and uncertainty of them all, reflecting discredit upon this branch of medicine, and inviting the introduction into popular practice of numberless proprietary preparations and patent nostrums whose only benefit is the tax they pay.

There is a measure of responsibility inseparable from our support of corporations whose high office is to prescribe in certain forms and combinations certain drugs for our profession to dispense. Progress in therapeutics is attained by individual observation and research, and not by the general and ready acceptance of advertised opinions.

Our object is to mitigate suffering and cure disease, and it were criminal folly to reject a remedy, of established efficacy, simply because we did not know its method of operation. Digitalis should be employed in valvular diseases of the heart, had experience only proved that it accomplishes the end desired, but its greater usefulness rests in the fact that it does so by lengthening diastolic and strengthening systolic action.

It is not my purpose to decry the worthy attempts of pharmacists, nor repel the advent of any agent which promises greater efficacy or exactness in therapeutics. With increasing and important developments in the various fields of pathology, we need equal advance in therapeutics, and we can never determine the merits of the new while we exclusively employ the old; but when on uncertain seas, let us not forget our unvarying compass, lest while steering from Scylla we are engulfed by Charybdis.

In composing this paper, my chief purpose was to place before the society for discussion some of our most recent remedies. My knowledge of and experience with them are too limited to encourage the hope of enlightening you upon their merits or modes of action. But for our own mutual good, and especially for my own gratification, I would evoke expressions from the members, to determine and agree upon their utility and indications for employment, in the light of our present knowledge concerning them.

I refer to antipyrin, phenacetin, antifebrin and acetanilid. We all know that the last two are one and the same, antifebrin being the trade name for the compound more properly called acetanilid. Antipyrin was discovered in 1884, by Dr. Ludwig

Knorr, of the University of Wurzburg, Bavaria, in an attempt to make quinine synthetically.

Antifebrin was prepared as a chemical by Gerhardt, in Germany, in 1852, but its use as a medicinal agent is of comparatively recent date.

Phenacetin, the last addition to this number, has been in use a shorter period than either of the others, though it has quickly won its way as their successful rival.

Chemically speaking, all these are of the coal tar series, are unstable, and cannot be given with acids or acid salts. Strong alkalies decompose them. Neutral salts are compatible with them. Phenacetin is the most stable of them all, and can be combined with a larger number of chemicals than the others. It is not decomposed by dilute nitric or hydrochloric acid. It is also the least soluble of them all. Antipyrin is easily soluble in less its weight in water, and I most frequently prescribe it with syrup of tolu. Antifebrin, or acetanilid, is less soluble than antipyrin, but can be conveniently mixed with whiskey. Either of these three can now be had in the form of tablets.

It is with the therapeutical action of these drugs that we are chiefly concerned. Their first claim was as antipyretics, but later observation proved also their ability to relieve pain. These two effects are generally conceded them now. I do not know that any curative power in any disease has been accorded them or, if so, that it has been established. It would greatly aid us, in our considerations, and enhance the interest of the paper to quote some popular opinions touching upon the pathology of fever, that we might look from cause, through its operation, to effect, but time does not permit, and I will only mention a few facts which force themselves into notice along the way.

The virtue of a drug is best determined by its combined action compared to other agents of the same class, in the accomplishment of a given result. How, then, do these medicines compare with others longer used and of established efficacy? Granting the necessity or expediency of reducing the temperature in a given disease, that agent is best which soonest and safest serves that end, and which at the same time least disturbs the other

functions of the body, physiologically performed, and aids in removing the cause or checking the progress of the disease upon which the elevated temperature depends.

The part which the nervous system plays in the production of fever is not yet fully decided ; though, in addition to the result of experiments bearing upon this question, the pathology of certain diseases, attended by characteristic elevation of temperature, proves the intimate relation between the accompanying fever and the impress of its cause upon the nervous system, though hardly determining the primary or secondary nature of either. Should the cause originate *de novo* in the nerve centers as appears in states of overwork, worry and exhaustion, or did the exciting agent manifest its impress through the intervention of the nerves that remedy would be most curative which directly, by stimulative, or sedative, or alterative action, restrained or neutralized its effect,

The *nidus* of irritation in inflammatory fever is evidently the phenomena of perverted action, the result of injury, whether that injury arises from external violence, or a poison without, or is the result of morbid material generated within the system. What best reduces the amount of irritation, whether by direct influence or by destroying the source, or checks the development or progress of the inflammatory process, is our most valuable and suitable antipyretic. Hence no agent, without positive action upon the heart, or influence upon arterial tension and the great sensorium as well, can successfully rival opium, veratrum and aconite in the treatment of this form of fever.

In this age, no one would attempt to cure malarial fevers without quinine or some form of cinchona. Neither of the remedies under discussion prevents a chill or an exacerbation. But in the continued type, one of them—preferably phenacetin—may be added for prompter results more grateful to the feelings of the patient.

In self-limiting diseases we do not hope to check their course by reducing the fever ; and it has been questioned how far we are justifiable in interfering with this symptom, yet the doctor of to-day would not be held blameless who neglected this feature of

treatment, and we owe it to our patient, as well as ourselves, to bring and maintain the various functions of the body as near their normal state as possible, or direct their action to a condition which we think best preserves the vitality of the system and hastens convalescence. Hence in diseases of debility, as typhoid fever, the question arises, are we by heroic measures to disturb its even course, or regarding it as a bridge supplied by nature to sustain the patient while all his forces are engaged in the active and uncertain contest with disease and death, withhold those agents which only attack the fever and leave its cause unmolested? Obviously it is better to reinforce than to supplant nature in her efforts to throw off the fetters of the enemy.

Her manner of doing this is seen in the malarial chill. So the spirit of mindererus or spirit of nitrous ether deserves preference over either of our new antipyretics in diseases of this class. Though I have had speedy and happy results from phenacetin when the aforesaid remedies had failed upon fair and extended trial. No one now disputes the antipyretic action of these drugs. They unmistakably effect the end for which they are given. The only question is, when they are indicated and which is to be preferred. Some think that antipyrin is the most reliable of them all. I favor and almost exclusively prescribe phenacetin. The only difference between antifebrin and acetanilid is in their cost, which is considerable.

But these remedies claim another besides the effect mentioned, and in this, perhaps, vary more not only in extent but in their seat of action.

Antipyrin impresses chiefly and almost solely the sensory matter of the cerebro-spinal system. Its most decided effect is upon the brain, and is one of our best remedies for headaches and neuralgias of the face. Its anodyne effect diminishes as it is removed from the head, or as the cause of the pain in the head is distant from it. I have never witnessed any positive action on the special senses or motor system, nor have I ever seen stupor produced by it even in the largest doses. I recall a case of rheumatism of long standing in which I pushed the drug to thirty grain doses every two or three hours, not even drowsiness resulting. While its effi-

cacy is not to be compared to a hypodermic injection of morphia yet when relief from pain is the end desired, and where stupefaction is to be avoided, or where opium is contraindicated by idiosyncrasy or fear of habit, antipyrin may be employed with great advantage.

The effect of phenacetin on the sensory apparatus is more general and save about the head, equally as decided as that of antipyrin. Perhaps no remedy was ever more liberally and universally employed than was phenacetin during the recent epidemic, of La Grippe which visited our country. Its independent adoption in the treatment of this disease stands as proof of the merit which it claims. In this, as you know, it acted most happily, reducing the fever and allaying pain, though it did not check the progress of the disease nor prevent the results. I observed, too, that the pain which followed La Grippe yielded more readily to salicylate of soda than to phenacetin.

Its prompt relief of the asthmatic symptoms which generally were present in La Grippe, as well as the terrible tormina of the bowels, lead me to hope that this apparent anti-spasmodic property might be applied in the treatment of other diseases, if not with kindred pathology, in which the same system of nerves was involved. I have since used it in asthma and was disappointed in the result, the patient complaining that her distress was intensified after taking it, and that she experienced more difficulty in expectoration.

I have never known death to be produced by either of these drugs, though it was supposed that a combination of calomel and antipyrin caused the death of a child in New York. Antipyrin is not as free from danger as antifebrin and phenacetin. Not a few cases of heart failure are reported as following its use. I have witnessed this effect only once in my own practice—where ten grains were given. In the case of rheumatism before alluded to, where it was given in enormous doses, there were no alarming symptoms, and none unfavorable excepting slight gastric and intestinal irritation.

Why and exactly how it depresses the heart's action, I think still remains unknown. The evidence is in favor of the supposition

that it impresses chiefly and primarily the resident ganglia of the heart. There is no disturbance of the other organs supplied by a common centre, which cannot be explained by the intimate relation and interdependence of their functional action, excepting it be that on the gastro-intestinal canal, which is either irritant locally, or the result of disturbance in the ganglionic fibres. But the fact remains and should be observed in its employment.

I have never heard of a similar effect following phenacetin, and since it has virtues equal to those of antipyrin, and is cheaper, I consider it preferable for general use.

Antifebrin sometimes produces prostration in an extreme degree, and is no more reliable than phenacetin as an antipyretic, and less than antipyrin as an anodyne. I use the chemical form when I prescribe it, especially for the sake of my poorer patients.

Therapeutics could have dispensed with these agents, but their undisputed merits have won them a welcome into our list of remedies, leaving their exact and relative rank to be determined by their more extended use.

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## WHAT ABOUT DR. KOCH, AND WHAT ABOUT INTENSELY SPECULATIVE MEDICINE?

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BY E. F. STARR, M. D., NACOOCHIE, GA.

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Professor Virchow, of Berlin, it seems has put his foot down rather emphatically on Koch's lymph—this world-renowned new discovery. He (Virchow) has said, in substance, it does not cure consumption, but produces inflammations in other parts.

I am not at all amazed at this announcement. It is about as much as I had expected. I had not been enthusiastic on this little matter that has kindled so great a fire in the world, medical and lay, or professional and lay, as I had but little faith. So we will have to try again. The siege shall still go on, but the

approaches will have to be made from some other direction or constructed in a different way. The lymph, from what I can learn, appears to be a ptomaine composed of different bacilli and glycerine, and is about as apt to be destructive to the *genus homo* as to the famed bacillus; and even if it were to destroy the microbe and leave the man intact, consumption would still exist and still go on and kill the patient all the same, unless something more could be done—some change were made, some revolution wrought, in the intrinsic status of the organism. The enemy is strongly ensconced, and the capture of a few stragglers will not dislodge him nor put an end to the struggle.

Except for the fact that it has been well conceded that enough germicides could not be introduced into the human system to destroy the microbes without jeopardizing the patient, Koch's device might be considered an ingenious one, but as it is, it was hardly so. He found, it seems, that the ptomaine of dead bacilli was poisonous to living bacilli, and concluded that by introducing it into the circulation he would destroy the bacilli that are said to exist with tuberculosis, and thereby cure the patient. It was ingenious enough upon the basis of his theory, but if this theory was not founded upon close-fitting facts, then his seeming ingenuity must lose its force and his theory must inherit the common legacy of all conjectures founded on false premises. Unfortunately for Dr. Koch he allowed the shout of triumph to be raised before he had gotten out of the woods. He has been, no doubt, an industrious investigator, and deserves credit for that much; and, moreover, if he had discovered and brought to the knowledge of the medical profession a practicable cure for consumption, he would deserve all the badges of honor and all the titles of distinction that could be conferred upon him. But such bestowments as these should be made with discretion. They should not be showered upon heads and bosoms that have not deserved them. This would be to disparage their value and to discourage the meritorious. Many an humble country physician, whose fame has not extended more than fifty miles from his centre of work, has done more for the saving of human life and the mitigation of human suffering than some of the most re-

nowned theorists of the profession. It might perhaps be germane here to inquire what practical benefit, what actual good, has resulted from the discovery of the comma bacillus and the cholera bacillus? Have there been more cases cured or have there been fewer victims to the encroachments of these diseases? If not, then *qui bono*? Of what good is it and where is the place for the throwing up of hats? Dr. Koch's researches may serve to forge a link in the golden chain, although I doubt it, but there will have to be more links added before the chain is long enough to reach the goal. Of course microphobists (for such have many become) will sneer at this, but let them laugh who win in the end. They (the microphobists) really seem to be laying the mines for their own destruction, and it even seems probable they will sooner or later spring them upon themselves. To all such I would commend the perusal of an article on "Professional Fanaticism" in the *North American Practitioner*, Vol. 2, No. 11. Among other things, he (Dr. Newomar) mentions a fact that I have been gathering from the reports of others, that pneumonia is more fatal to-day than it was thirty or forty years ago. I have been noticing this for years. Most of our prominent men die of pneumonia, and whenever it is announced that the distinguished Mr. so-and-so is sick of pneumonia, another announcement soon follows that he is dead. It has gotten to be so that I invariably expect this second announcement after the first. Indeed, in this day of "advanced thought" and "marvellous progress," in this last quarter of the nineteenth century the treatment of the acute phlegmasiæ has become sadly retrograde and fearfully unsuccessful. This ought not to be. It is a standing disgrace to the profession, and ought to be wiped out; but it will never be wiped out as long as the profession throw away common sense methods and rational treatment that long have stood the test of experience, and join in the chase, the wild hunt, after microbes, fine-spun theories and other such immaterial foolishness.

It is unfortunate for the sick that bacteriology was ever so enthroned in the mind of the profession. It afforded such a chance for hobby riding, and doctors do love to ride hobbies, oh, amazingly! Unfortunately, ever since its enthronement and ever



since the assertion by Dr. Austin Flint that pneumonia was a limited disease, or had a certain course to run, and was an infectious disease, the poor victim of pneumonia has had to pay the penalty, even more than before, with his life. Ever since, even more than before, the treatment has gone crooked. I believe the theories of Dr. Koch and Dr. Flint have both been deleterious. I have been practicing medicine about forty-seven years, and I can remember many cases of pneumonia and acute bronchitis and other phlegmasiæ recovered then, and I can see from the reports how they die now—not from change of type, but from change of treatment. It distresses me.

There is no royal road to recovery from an acute phlegmasia, and I would advise all young practitioners, if they have Dr. Flint's practice, after noticing what he says on diagnosis and pathology, to close the book and lay it away out of sight, or else carefully cut out and burn what pertains to treatment, especially of pneumonia. So much absorbing interest devoted to microscopic studies and so much noise made about the infinitesimal serve to direct the minds of practitioners from rational and established methods, while the theories that result are on a par with the magnitude of the objects discovered. This last is said, not of Dr. Flint, but of the tendency of the times.

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### TETANY.\*

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BY E. H. SMALL, M. D., PITTSBURG, PA.

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On November 29th, 1890, I was called to see M. B., a fat, healthy-looking, breast-fed baby boy, aged 11 months. His hands and feet were much swollen, œdematous, and of a cyanotic tinge. His mother said that they had been "spotted," *i. e.*, ecchymotic, before I had come. The fingers were strongly flexed at the metacarpal phalangeal joints, while the phalangeal

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\*Read before the Allegheny County Medical Society, March 17, 1891.

joints were as strongly extended. The thumbs were adducted and flexed. The feet were extended at the ankles as in talipes equinus, while the toes were strongly flexed. Attempts to straighten out these contractions caused great pain. The mother said that at first the child cried a good deal, and that his hands and feet were tender and painful. So much were the hands and feet, particularly the dorsal surface, swollen, that I suspected nephritis. The urine, however, contained no albumen. The child had always been strong and healthy, having had no other sickness.

Two days before, Thanksgiving, the child had been given some turkey and cranberries to eat, which had caused indigestion. When I called he had had no satisfactory movement of the bowels for some time. I gave him two one-half grain doses of calomel one hour apart, and twenty drops of the elixir of bromide of potassium four times daily, and told the mother to rub his hands and feet with alcohol and water. The next day he was much better. I directed hot fomentations to be applied to the hands and feet instead of the rubbing with alcohol and water. In a week the child was about as well as usual.

Four weeks before his gums had been scored by another doctor. A few days before my visit, the two first teeth had appeared, *i. e.*, at eleven months. The anterior fontanelle was larger than normal for his age, and the costo-chondral articulations were rather more prominent than normal. He has an older brother and sister who are perfectly healthy.

When I first saw this case, I thought it to be one of tetany, and its course and termination have proved it to have been such.

I had never before seen this disease in a child, but had seen one case in Vienna in a pregnant woman.

Although this disease has doubtless always existed, and although it was described as far back as 1831 by a Frenchman, M. Dance, as occurring in an adult, and in 1832 by another Frenchman, M. Tonnele, as a new convulsive disease of childhood, yet it is but seldom mentioned in the more common medical textbooks. The name tetany was first given it by Dr. Corvisart,

in 1851. Dunglison's Dictionary, 1874, speaks of "Tetanilla" diminutive of tetanus, saying that this disease is also called tetany.

Dr. Smith, of New York, defines it as "a disease in which there is a tonic contraction of the muscles, commonly those of the extremities, but sometimes also those of the face or trunk, produced by causes external to the nervous system, and usually of temporary duration." This definition shuts out true muscular contractions arising from disease of the brain or spinal cord, in which the contractions are both but a symptom, and not the disease itself. Henoeh describes it under the name of "Idiopathischen contracturen" and regards it as a kind of abortive form of convulsions. Dr. Cherdle, of London, says, "Laryngismus, tetany and general convulsions are the positive, comparative and superlative of the convulsive state in childhood."

**CAUSES.**—Cases are recorded between the ages of six months and sixty-one years. Most cases occur in infancy and childhood; more in males than in females. The most common cause seems to be disorders of the digestive system, as diarrhœa, habitual constipation, worms, and dentition. Charles Warrington Earle, of Chicago, gives a case of a healthy girl two and one half years old, in whom tetany occurred on the day after she had eaten heartily of fried potatoes. Perhaps my case was caused by the turkey and cranberry sauce of Thanksgiving, two days before.

It may arise in persons who are in poor health from other diseases, as pneumonia, bronchitis, cholera, typhoid fever and dysentery. Exposure to wet and cold has seemed to cause it. Hence some think it a rheumatic affection. Erb says: "Many physicians have regarded it as an exquisite example of rheumatic disease." In adults, commencing puberty, pregnancy, as in the case I saw in Vienna, and nursing, may cause it. Rachitis is also regarded as a cause, which may hold in my case, on account of the delayed dentition, large size of fontanelle and enlarged articulations.

**SYMPTOMS.**—In patients old enough to describe their symptoms, tetany begins with pain in the head and an uneasy, tingling, burning sensation in the limbs. In children, the objective symptoms are those first noticed. The peculiar shape of the hands

and feet, their rigidity, and pain on pressure are the commonest symptoms. Generally the fingers and toes are flexed on the palms and soles, occasionally extended. At times the joints of the hands and feet are also affected, or the elbow-joint—so that the fore-arm appears flexed upon the humerus, the hands upon the fore-arm, and the foot upwards, or else towards the sole. The thighs may be adducted, or flexed, the legs extended or flexed, and the feet extended as in talipes equinus. The contractions are always bilateral and symmetrical. Attempts to straighten out the contractions cause pain. Œdema, with a cyanotic tinge of the back of the hands and feet and occasionally ecchymoses, produced according to Henoch, by the pressure of the contracted muscles on the intermuscular veins, is oftentimes present. In severe cases the muscles of the trunk and head may be affected, but this is rare in children. Trousseau's sign—compression of the artery and nerve supplying the contracted muscles increasing the contractions—can be sometimes observed. The electrical excitability of the nerve supplying the affected muscles is increased, as is also the patellar reflex.

**DIAGNOSIS.**—This may be made out by the peculiar grouping of the symptoms, the characteristic position of the extremities and the absence of cerebral and general disturbances. Tetanus neonatorum and organic disease of the brain and spinal cord are the principal diseases with which it may be confounded. Tetanus generally occurs within a few days after birth, almost never after the first month; tetany is very rare under the age of one month. In tetanus the muscles of mastication are early affected; in tetany the contractions begin in the extremities, and the muscles of mastication are never, or only in the last stages, affected. In tetanus the symptoms tend rapidly to become worse and worse, generally ending in death; in tetany, as a rule, the child is soon well. Tetanus is in some way connected with injury to the umbilicus, or umbilical cord; in tetany trauma has nothing to do with the case. In organic diseases of the brain the contractions are usually limited to one side, with other symptoms of brain involvement; in tetany the contractions are bi-lateral.

**PROGNOSIS.**—In children tetany, when uncomplicated by grave

disease causing it, almost always ends in recovery, though it may recur. The duration is from a few days to several weeks or months—indefinite.

**PATHOLOGY.**—Since tetany in children is so rarely fatal, and then usually from the complicating or causative disease, but few autopsies have been made, and in these no lesions have been found which seem to bear a causal relation to the disease. Herz says that clinical phenomena indicate that the disease is due to anæmia of the cord.

**TREATMENT.**—When the cause is known, especially when from disease of the digestive system, its removal will soon be followed by the disappearance of the disease. Bromide of potassium in doses according to age should be used. Chloral and calabar bean are recommended. Envelop the hands and feet in hot fomentations ; or use massage with alcohol and water. A child of fifteen months recovered in one week on gr.  $\frac{1}{4}$  zinc sulphate and gr.  $\frac{1}{192}$  atrophia sulphate, thrice daily. This is all that is necessary in children. In adults cannabis indica and morphia hypodermically have been used with good results.

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## THE GENERATION OF ANIMAL HEAT IN THE LUNGS.

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BY A. D. BARR, M. D., CALAMINE, ARK.

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Lavoisier maintained that the lungs might be considered as the principal centre of the generation of animal heat. This idea was soon proven to be erroneous, since which time the lungs have been credited with the production of a very inconsiderable amount of the total heat produced by the human body. Since such very important chemical changes take place in the lungs, it becomes very interesting to examine into these changes and see if any chemical combinations occur that will account for the production of any important amount of heat. In the study of digestion, we

find that the fats are absorbed by the lymphatics, and are poured into the blood current at the junction of the left internal jugular and subclavian veins. From here they pass, as fats, to the heart and thence to the lungs. In the lungs the fats seem to be acted upon by the oxygen, and so changed that they are no longer recognized in their original form. In their transformation they yield heat, which is capable of being converted into other forms of energy. Sugar may also be traced to the lungs, where, ordinarily, it is so decomposed that it can be no longer recognized, and in its decomposition it also yields heat, which is the result of all chemical combinations. The union of the oxygen of the inspired air and the hæmoglobin of the blood is of course followed by the production of heat.

Having seen that important chemical combinations take place in the lungs, it becomes important to see if we can arrive at an approximate idea of the amount of heat there generated. This is best done by considering the mode by which heat is lost in the percentage form. Helmholtz considers that 2.6 per cent. of the total heat is expended in heating the food; 2.6 per cent. of the total heat of the body is expended in heating the air inspired, supposing its temperature to be raised from  $20^{\circ}\text{C}$ . to  $30^{\circ}\text{C}$ .; 14.7 per cent. of the total heat of the body is expended in evaporating the water eliminated by the lungs; 80.1 per cent. of the total heat is expended by radiation, conduction and by evaporation of water from the skin. According to the above  $17\frac{1}{4}$  per cent. of the total heat produced by the body is given off by the lungs. The next question is, if no heat is generated in the lungs worth taking into consideration, what is the amount of the total heat that is conveyed to the lungs by the blood? This can best be answered by ascertaining the proportion in which the blood is distributed to the different organs, which, according to Ranke, is, that one-fourth of the total amount of the blood is contained in the muscles, one-fourth in the liver, one-fourth in the heart and great vessels, and one-fourth in the remaining organs. Now the remaining fourth of the blood, according to Ranke, is to be divided between the brain, the spleen, the kidneys, the stomach and intestines and the lungs.

Say, give the lungs one-sixteenth the total amount of the blood and they will contain 16 per cent. of the total heat of the body. Then 16 per cent. of the total heat of the body is contained in the lungs, and  $17\frac{3}{16}$  per cent. of the total amount of the body-heat is given off by the lungs; thus it is evident that more heat is given off by the lungs than these organs could possibly contain unless a very considerable amount of heat was generated in them. And, again, if no heat was generated in the lungs, the blood returned from these organs, instead of being reduced about one-third of a degree F., would be reduced to zero. For these reasons I am forced to conclude that a very considerable amount of the entire heat of the animal body is generated in the lungs.

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## "HIP JOINT DISEASE."

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By P. H. FITZHUGH, M. D.

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*Concluded.*

### DIFFERENTIAL DIAGNOSIS.

The affections most frequently mistaken for hip disease are: 1, Synovitis; 2, Lumbar, Pott's; 3, Neuroses of the Hip; 4, Infantile Paralysis; 5, Peri-Articular Disease; 6, Peri-Nephritis and Peri-Typhlitis; 7, Congenital Dislocations.

The symptoms of beginning hip disease and those of synovitis may be so similar that a diagnosis at first is impossible. Synovitis may begin suddenly without known cause, or following a fall, with extreme pain, fever, immobility and swelling. These symptoms may soon subside and complete recovery of the joint follow; or the subsidence may be more gradual, the symptoms lasting for months. All of the usual joint symptoms, such as muscular spasm, etc., may be present in chronic forms of synovitis. In adults synovitis comes on most frequently after a fall, or traumatism of some kind. It is much more common

in adults than in children. Where recovery takes place in a few months or less, in cases marked by characteristic hip disease symptoms, it may be inferred that osteitis never existed, but that it was purely a synovitis.

Lumbar, Pott's disease, may cause a limp and restriction of motion of one hip, thereby simulating hip disease so closely that it may be very difficult to diagnose. As a rule the motion is only limited in one direction, viz., hyper-extension; the contraction of the psoas producing this result may be caused by the descent of pus into the psoas or to irritation reflex to the disease. Where an abscess burrows near the joint it may so irritate the joint that all of the motions will be restricted. This, however, where the joint is not involved, soon passes off under proper rest, with the exception of restriction to hyper-extension or extension. Abduction, which is limited very early in hip disease, most often remains free in even well marked cases of psoas contraction. Hysterical hip may resemble true hip disease in many particulars. Excessive pain may be complained of, especially on manipulation, but the pain is more apt to be *referred* to the *hip than the knee*; while the *reverse holds good* in true hip disease.

Atrophy may or may not be present.

On examination the limb is usually held very stiff, unless the attention of the patient can be withdrawn, when motion will be greater. I remember examining a woman who presented herself at the hospital for double hip disease. She walked very poorly, allowing only the slightest amount of motion at the hip joints. On examination in the recumbent position, we found all motions limited; neither thigh could be flexed to an angle less than  $160^{\circ}$ , but the patient, on being told to get up, flexed the thigh to about  $90^{\circ}$  which confirmed beyond a doubt the diagnosis of hysterical hip.

Congenital dislocation can hardly be mistaken for hip disease; the limp being the only symptom, and this having existed since the child commenced walking. In hip disease the limp is not congenital. There is no limitation of motion, muscular spasm being entirely absent.



**INFANTILE PARALYSIS.**--In occasional cases there may be at the beginning of the paralysis "extreme pain and tenderness with immobility of one limb; ordinarily these symptoms are not accompanied by other symptoms of hip disease," and are followed by loss of power and warmth of the affected limb, atrophy of the whole limb rapidly taking place.

Peri-articular disease may be recognized from the inflammation attacking certain groups of muscles, causing a limitation to motion greater in one direction than another, "while in true joint disease the limitation is equal in all directions of the normal motion of the joint."—(Bradford and Lovett.)

Peri-nephritis and peri-typhlitis have been mistaken for hip disease. These affections may present psoas contraction with or without iliac abscess. The limitation to motion is not general, affecting principally extension; abduction, etc., remaining quite free.

#### PROGNOSIS.

Under favorable circumstances the tendency of hip disease is to recovery, with more or less deformity, the amount of deformity depending largely upon the mode of treatment and the care taken of the patient. Cavin reported eighty cases of suppurative hip disease treated at the hospital at Berck; in the course of five years 50 per cent. were cured;  $12\frac{1}{2}$  per cent. died; 25 per cent. were not cured;  $7\frac{1}{2}$  per cent. were improved when removed.

"In fifteen cases of suppurative coxitis with albuminuria, five died under conservative treatment; two were discharged improved; six not improved; two cured. These cases of Cavin's were, with the exception of ten, severe cases sent from the Paris hospitals after they had ceased to improve there." Gibney, from an analysis of 288 cases, reported a mortality of  $12\frac{1}{2}$  per cent. from exhaustion, meningitis and amyloid degeneration. "Shaffer and Lovett investigated fifty cases of cured hip disease which had been discharged from the New York Orthopedic Dispensary at least four years previously, and found that forty-one had remained cured. Of the remaining ten, four had died, and six

had relapsed, although four of the latter had been apparently cured a second time."

In ninety-six deaths after suppurative hip disease at the Alexandria Hospital, London, the causes were as follows :

Meningitis, . . . . .	16.7
Albuminuria from dropsy, . . . . .	20.8
Phthisis, . . . . .	5.2
"    and albuminuria, . . . . .	3.1
Exhaustion, . . . . .	9.4
Erysipelas and pyæmia, . . . . .	3.1
Intercurrent disease, . . . . .	7.3
After operation, . . . . .	9.4
Unknown, . . . . .	25.0

In fifty-one cases investigated at the New York Orthopedic Dispensary and Hospital, treated by purely conservative means, fifty-one cases were discharged cured. Forty-one of these remained well and were able to do a full day's work at their respective occupations; only one case, and that combined with Pott's disease, used a cane; none used crutches. Among these were printers, mechanics, errand boys, shop girls, school children, etc., and none presented any evidence of active tubercular disease, or serious incapacity from deformity. Dr. Gibney, in 1878, reported eighty cases cured at the hospital for Ruptured and Crippled, New York, by expectant treatment and internal medication. Forty-eight developed abscesses; in the remaining thirty-two, none had abscess. Thirty-three of these cases ran their course in three years, twenty-eight in from three to six years, and in nineteen cases from six to ten years. At the termination of the disease, sixty-one of these patients could walk and run without discomfort; twelve walked fairly, at times requiring a support, and seven could walk only with the aid of crutches. In twelve of these cases an arc of at least 15° of motion existed in the afflicted joint. From one to three inches represented in the majority of cases the amount of shortening.

In few diseases is the good effect of thorough, skilful treatment, more evident; but it should be continued for some time after all signs of the disease shall have disappeared.

The average length of time required for treatment is about  $2\frac{1}{2}$  to 3 years, but it is better to continue the treatment six months or a year longer, than to remove the splint one week too soon, for extension and immobilization of the joint for a year longer could produce no damage, whereas the change to a convalescent splint too soon may produce a severe relapse. The presence or absence of abscess does not seem to affect the outlook in regard to motion. In hip disease, where proper and skilful treatment is commenced at an early stage and continued for some time after all symptoms have ceased, the prognosis as to the position and function of the limb is favorable; but, should recovery take place with the limb ankylosed in a distorted position, such as marked flexion, abduction or adduction, the deformity can be entirely overcome, and a useful limb restored by means of operative interference. The real shortening existing will be permanent, but this, unless great, will not be of much moment, as tilting of the pelvis will readily assist in equalizing the length, or the shoe of that foot may be built up.

The atrophy also is claimed never to be entirely cured, but as soon as the patient removes the splint and begins to use the limb, the atrophy diminishes very much.

#### TREATMENT.

The object in the treatment of hip disease should be to afford protection, fixation and extension to the diseased joint; to prevent deformity, build up the general condition, and at the same time keep a lookout for and be prepared to meet any and all complication, such as abscess which may arise. I will not describe many of the different modes and appliances for the treatment of coxalgia, but will only mention the principal ones in daily use, at the hospital for Ruptured and Crippled, New York. For fixation are used: 1, plaster Paris; 2, wire cuirass; 3, Thomas hip splint; and 4, De Pass's modification of the same. The plaster of Paris, as ordinarily applied, does not produce the desired amount of fixation, from the fact that it does not grasp the trunk firmly enough to prevent motion in the lumbar vertebræ. This permits the pelvis to move within the bandage, allowing

motion at the hip. While this objection is very vigorously urged by many orthopedists, still the writer is convinced that it is largely and scientifically exaggerated. In the writer's opinion it can be so applied as to produce as fine fixation as any purely fixation splint known to him. Prepare the patient as follows: First, grease with vaseline—I am aware that this step is objected to by some, but they are largely in the minority—hold the limb in as good position as possible, pad well the bony prominences and lower ribs, then run a spica bandage of thin cloth from the toes to and including part of thorax; over this apply a light, smooth plaster Paris bandage, being very careful to remove all “bricks,” or lumps of plaster Paris, and have each layer perfectly smooth, so that there will be nothing liable to excoriate.

A plaster Paris bandage applied to the naked skin, nicely and smoothly, need give no alarm in regard to excoriations. It is the roughly applied, lumpy bandage, one layer being tighter than the other, which causes the trouble. Increase the strength by a light bar of steel running over the groin, and by reinforcing with the bandage at this and other weak points. By this means, we have a light, firm and solid support from the malleoli to very near the axillæ. This having been applied without much padding must necessarily hold the part pretty firm. It certainly affords the greatest amount of relief to the most exquisitely sensitive joint. I have frequently seen children, crying from intense pain, who were relieved a short time after this application, and remained so until after its removal.

The “wire cuirass” furnishes very good fixation, but it is quite expensive, and more uncomfortable than the plaster Paris, and is not at all fitted for dispensary work.

Thomas' fixation hip splint, invented by Hugh Owen Thomas, of Liverpool, is largely used, both in this country and in England. It is a very useful splint, and has many redeeming points. It is very simple of construction, light in weight, and quite firm and secure when properly adjusted in its object of fixation. It consists of an iron bar extending from the inferior angle of the scapula to the lower third of the posterior surface of the leg; to the upper end is attached a band encircling to the waist at right angles

to the upright iron bar. Just below the gluteal fold, and at the lower end of the upright bar are placed other bands at right angles encircling about two-thirds of the thigh and calf respectively. This is held in position by a canvass lacing around the trunk and bandage to the limbs. It can be so bent as to fit any angle of deformity, and gradually straitened as the spasm of the muscles wears off. Mr. Thomas claims that by this means he can afford protection and fixation to the joint, and at the same time correct any existing deformity, *i. e.*, where it is not due to bony ankylosis.

While this splint has given remarkable satisfaction in Mr. Thomas' hands, it has not done so well by others, and we are convinced that fixation can hardly be made absolute.

My friend, Dr. Matt De Pass, of the hospital for Ruptured and Crippled, New York, has so modified the Thomas hip splint as to vastly increase its usefulness. He extended the length of the posterior iron bar to two or three inches below the sole of the foot, when it bent at right angles upon itself; to this bent piece is attached a cross bar with straps at each end; these are fastened to buckles in adhesive plasters applied to the leg. By this extension can be produced, counter-extension being obtained by two perineal straps fastened to an additional band encircling the pelvis at right angles, and attached to the posterior bar.

The writer remembers two girls with very acute "hips" on whom had been tried the Thomas splint without any amelioration whatever; in fact they were apparently daily growing worse from inability to keep the splint perfectly adjusted. On these two Dr. De Pass applied his modification. For some time previous they had been averaging from twenty to thirty-five "night cries" every night. The night following the application of the modified splint the cries were reduced about 50 per cent.; on the second night one was reported as having cried eight times, the other less. The improvement was not merely temporary, but permanent.

On the sound foot a  $3\frac{1}{2}$  to  $4\frac{1}{2}$  "Patton" is applied, the patient using crutches. This prevents any standing on or jarring of the diseased limb. This "Patton" is used in connection with all

Thomas traction splints. The objection to all of the purely fixation splints is, that they do not prevent the muscular spasm from crowding the head of the femur into the acetabulum. This spasm prevents rest of the joint, increases the existing inflammation of the bone, and permits destruction of the femur and enlargement of the acetabulum, thereby contributing to the distortion of the limb.

The traction splints used are known as the "Taylor Hip Splint," or Gibney's modification, the "Polyclinic Hip Splint." The virtue of these, as in fact all traction splints, depends upon practically the same principle, *i. e.*, traction on the limb with counter-traction or resistance at the perineum. Taylor's splint consists of a pelvic girdle; two perineal straps and a long outside bar extending from the trochanter to any desired length below the foot, the upper end of this bar is attached firmly by a screw to the pelvic girdle, where it passes over the trochanter. The lower end is broadened and bent upon itself, so as to pass under the foot at right angles. To this broadened foot piece is attached two leather straps which can be fastened into buckles secured to the adhesive plaster on the patient's leg. The stem consists of two pieces; one "hollow at the lower part, with teeth cut on the edge into which a rod plays, by means of a key." The rod can be moved up and down, and it is caught and held in place by means of a spring and sliding catch."

Gibney's modification, known as the "Polyclinic Hip Splint," is similar to the above, with the exception of the stem being made of one piece. To the foot piece of this stem may be attached a windlass with a ratchet, to which the traction straps are fastened. By turning the key to the windlass traction to any desired extent may be made. Unless great care is taken the perineum is very liable to become excoriated. It should be bathed with 50 per cent. alcohol frequently, and dusted daily with some dry impalpable powder, such as talc, subiodide of bismuth or zinc oxide. A most excellent application, one that I recommend from personal experience, is

R. Pulv. amyli., 3vi.

Pulv. zinci oxidī, 3iss.

Pulv. camphoræ, 3ss.

M. Sig.—Dusting powder.

The leg is quite apt to excoriate, hence the plaster should be removed on an average of every two weeks.

The excoriated leg should be treated as the perineum, or an ointment, such as the following may be applied :

R. Acid salicylic, gr. xv.  
Pulv. zinci oxidi,  
Pulv. amyli., aa. 3ii.  
Vaseline, q. s. ʒi.

# M.

The weight and pulley are a valuable addition in the treatment of malpositions due to muscular spasm. The patient being put on a "cabbot frame" with an incline and traction made in the line of deformity, which is corrected daily as the spasm decreases. Where the deformity cannot be corrected by the weight and pulley it may be necessary to resort to surgical procedures, such as: 1, Manual force under ether; 2, tenotomy, myotomy and fasciotomy; 3, osteotomy.

"Bessement force" under ether is often all that is necessary. At all times it is worth the trial before more radical procedures are resorted to. The objections to this are the liability to fracture when an undue amount of force is used, and the possibility of re-establishing the disease from the setting free of an encapsulated focus of tuberculosis material, which had become inactive. Myotomy, etc., should be resorted to when the above procedure is not sufficient to correct the deformity, and you can feel the tense bands holding the limb. Cut subcutaneously and divide carefully all constricting bands. One can hardly cut too much, provided he avoids the larger vessels and nerves.

When bony ankylosis has occurred subtrochanteric osteotomy, known as "Gant's operation," is by far the most preferable. Mr. Gant, in the *British Medical and Surgical Journal* of October 18th, 1879, states the following as the reasons why his operation is to be preferred: "When, in consequence of continued disease of the hip-joint, the head of the femur has disappeared, leaving only a stunted nodule of bone representing the neck above the trochanter, in such a case the operation of section in the femoral neck cannot be performed, there being no neck to

divide. Even when supra trochanteric section is practicable, the state of the neck may render the operation abortive. The seat of the operation will be in an almost carious portion of the bone which is unfit to yield a fibrous union." In Gant's operation the psoas and iliacus, acting above the division, are not so apt to reproduce flexion as in the older operations, where they acted below the point of section.

Provided with a chisel and mallet, the patient lying on the sound side with a sand bag between the thighs, the skin having been thoroughly scrubbed and washed with bichloride, sol. 1 to 3000. About an inch or an inch and a half below the trochanter major, push the chisel with the blade in the long axis of thigh, down to the bone, through the periosteum, when it is turned until its edge is at right angles to the long axis of the femur. The chisel or osteotome should then be driven by sharp blows with the mallet first forward then backward until the shaft has been cut about three-quarters through, when an assistant grasps the pelvis, the operator attempting to complete the division by fracture. Should this not be possible, repeat the chiselling until it is. The bone breaks with a loud snap and can generally be brought into the divided position without further trouble. Oil silk is then applied over the incision; around this, bichloride gauze and cotton, then a plaster of Paris spica. This is allowed to remain about four weeks, unless indications to the contrary should prevent. When it is removed and the position and condition of the limb noted, another plaster of Paris is applied for about two weeks longer, an ambulatory splint being then substituted.

Simple uncomplicated abscesses need cause no alarm. They may be left alone or aspirated. Should it become extensive and painful, free incision, thorough scraping of the sac and diseased focus, irrigation with bichloride, 1 to 4000, and dusting with iodoform should be resorted to. The incision may then be closed with silk or left to close by granulation. Salicylate of soda, antifebrin, opium, chloral, and the bromides have all been used with varying degrees of success, for "night cries." The main objection to their use is the injurious effect of the narcotics upon



the appetite, digestion and nervous system. The most efficient means are fixation, with extension made in the line of deformity.

No general rule can be laid down for the proper treatment, each individual case being a study within itself. In one case firm fixation with rest in bed for some time may be deemed advisable, owing to the sensitiveness of the joint or activity of the ostitis, while in other cases ambulatory appliances from beginning to end will be all that is necessary. As the *pain* and *muscular spasm* pass off, the traction may be suspended and the joint merely protected from jar as long as there is any possible tendency to a recurrence of the muscular spasm. By a proper appreciation of the symptoms, meeting all as they present, and the continuance of the treatment very carefully, for at least a year or two, with a vigilant supervision and protection for several years subsequently, we should expect the diseased limb to recover without distortion and with considerable if not almost perfect motion.

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## ONE HUNDRED CONSECUTIVE CASES OF SKIN DISEASES.

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### V.

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By M. B. HUTCHINS, M. D.,

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[NOTE.—In preceding article there are a few typographical errors, the worst being in the last prescription, where "*Lanolin pulv.*" should, of course, read, "*Lanolin pur.*" (pure), which I overlooked in the proof.]

### ACNE VULGARIS.

The time of occurrence of this form of acne is put between the ages of fifteen and thirty, the disease usually beginning at puberty. Beginning on the face, as a rule, about this time, it may subside or disappear by twenty-five, or may then have begun to

appear on shoulders, back and chest. The youngest patient with this disease, which I recorded, was nineteen, the trouble having been present since fourteen. The oldest was a man of twenty-eight, who had an occasional lesion on the face, but a most severe outbreak on the back and shoulders. The disease began on his face at sixteen, on chest at eighteen, an occasional lesion still occurring there ; and on back it appeared at twenty-two. After six months' most faithful following of the treatment he was entirely free of the disease. A particular type of acne lesion did not occur in the majority of the cases, but there was present every form of papule, pustule or nodule which occurs in acne, from the simple "black head," the small papule or papulopustule, acutely or indolently inflammatory, to the large finger nail, or larger-sized, firm, inflammatory mass, containing only sebaceous matter, or, later, pus. The disease belongs essentially to the indolent inflammatory processes, and I have not seen a case which I thought required preliminary, "sedative" treatment.

Here, as in the description of seborrhoic eczema, I confess to using scarcely more than one remedy, of course varying the strength as the skin required. Below is the "average" :

R. Zinci sulphatis,  
Potasii sulphidi,  
Sulphur. precipitat., aa. ʒi.  
Aquæ, ʒiv.

M. Sig.—Shake, apply and let dry.

This must be made with regard to chemical reactions. Sometimes half the fluid may be alcohol—in order, for one thing, that the application may dry more quickly. The "rotten egg" odor may be partially suppressed by the use of rose, instead of plain, water.

Constipation was practically the only deviation from normal health, nothing else, as a rule, being found "wrong." Constipation was treated with the "cascara and nux" mixture already described, and generally this treatment was successful. Where slight "dyspepsia" was noted simple "vegetable tonics" were

prescribed, but the majority of cases neither received nor required internal treatment.

Besides the application of the lotion above mentioned, I have found pressing out the "black heads" (comedones), puncturing every lesion without regard to its stage, form or character, and pressing out contents—whether simple sebum or pus—to be extremely useful in hastening the decline of the eruption. Applications, at night, of very hot water to affected skin had a pleasant and useful tonic effect. If much greasiness and oiliness of the skin were present, an aqueous alcoholic lotion, containing three per cent. of resorcin, was found useful. On that severe case of the back, frictions, with

R. Saponis viridis, ʒii,  
Sp. vin. rect., ʒi,

M.,

were found beneficial as a local stimulant and to remove effete epidermis.

The disease is a kind of physical barometer, tending, as it does, to relapse after the occurrence of a slight indigestion, constipation, or such variation from health.

Various dermatologists, quoting the view that sexual continence had some influence in the production of the disease, I made inquiry concerning the personal habits of the majority of the (male) patients, and found continence rather lightly practiced. It is more likely that irregularity in the sexual life has an influence. Masturbation was not inquired into.

Persistence in treatment was rewarded by recovery; the patients who treated themselves spasmodically are to be assured that they will *outgrow* the disease some day.

#### ROSACEA—ACNE ROSACEA.

Of these cases I find three recorded. It is difficult to differentiate between the two affections, for we find slight evidence of the acne in the majority of the rosacea cases, thus rendering the designation *acne rosacea* appropriate. This disease is commonly found to begin about the age when common acne should disappear, but I had one case, the driver of a delivery wagon, age twenty-one, in which simple acne, chiefly composed of come-

done and small papules, was present, and, besides, a condition of dilatation of the capillaries of the skin—probably due to exposure to all sorts of weather. Quite a typical case of acne rosacea was that of a lady of thirty-two. There was flushing of skin of cheeks and nose, end of nose a dull red, and dilated vessels, with here and there a pin-head sized, indolent papulo-vesicle, or pustule, simulating minute acne lesions. Follicles of nose were dilated, and many were filled with dried sebaceous matter. Skin of face was oily, and there was considerable dandruff on the scalp. Uterine derangements existed, sufficient to produce sterility.

The seborrhoeic condition was treated with the *lotio resorcin*; the acne rosacea directly, with the lotion for acne vulgaris, omitting the sulphur. Vessels which are too much dilated to yield to treatment with lotions, etc., can be destroyed by electrolysis, just as the dilated vessels in "birth marks" can be destroyed. In acne rosacea it is important to find out if there be functional derangement of any kind, to direct internal medication towards its removal. The hot water applications, as in common acne, are also every useful in this disease. Protection from sun, wind and artificial heat are essential. The cases require long continued and persistent treatment, and deviations from health must be remedied. Finally, the possession of a red face or red nose is more frequently due to other causes than to indulgence in alcoholics.

16½ Whitehall St.

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Lawson Tait says: Where syphilis kills its tens, gonorrhœa kills its thousands; and it would take the sufferings of a hundred cases of syphilis to make up for the long, weary years of agony of one case of gonorrhœa pyosalpinx.—*N. Y. Medical Times*.

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The State Medical Society of Michigan has had a bill introduced into the legislature to regulate the practice of medicine in that State. It seems to have been carefully drawn, and deserves to become a law.—*Medical Record*.

## Society Reports.

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### GYNECOLOGICAL AND OBSTETRICAL SOCIETY OF BALTIMORE.

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February meeting.

The President, DR. HENRY M. WILSON, in the chair.

DR. NEALE reported the following case of

OCCLUSION OF THE OS UTERI DURING FOUR DAYS' PARTURITION.

Mrs. K. W., aet. 26 years, white—1 para. Past history unimportant. Last menstruation, early part of April, 1890. Pregnancy normal up to November 16, 1890, when she slipped and fell violently on her right side on the sidewalk. There was no vaginal discharge at the time and no discomfort except from the jar, bruisings, etc., and the patient was up and about all the time. The movements of the child were felt after the fall.

About Christmas, 1890, an offensive yellowish vaginal uterine discharge occurred and continued for one week.

On the night of January 12th, 1891, her first labor pains began and were so severe as to require morphine given by her attendant. There was no "show" or discharge of any kind. The pains increased and the patient was suffering severely when I saw her for the first time, Friday evening, January 16th, 1891. She was a large, well-built and well nourished woman.

Could not distinctly map out the child by abdominal palpation. By auscultation gurgling over the entire uterine tumor, and not a trace of foetal heart sounds could be heard. By vaginal examination: very short and small vagina, no cervix and no os! A continuous layer of mucous membrane, flush with the vaginal walls, closed over the entire vault of the vagina and a little dimple in its centre was the only indication of where the os ought to be.

Patient chloroformed, placed in position, hand passed into vagina, finger pressed firmly against the dimple, when it suddenly yielded or burst open like a membranous web—permitting a gush of *not* foul smelling, bloody water to escape, and at once the rapidly enlarging outlines of the os could be felt, then about as wide as a silver half-dollar piece. The soft bagging scalp and loose cranial bones came down upon the enlarging os, and as the expulsive efforts were almost *nil*, I grasped the head with a Simpson's cranioclast, which tore away, and then the blades of a Tournier basiotribe were adjusted over the head and neck, and a thoroughly macerated but not decomposed or foul small child was easily extracted. Perineum intact—os fissured slightly. Small placenta expressed within six minutes. Considerable *post partum* hemorrhage, uterus acting feebly. Os remained open about size of silver half dollar piece, thick edges, uterus rather small but not firmly retracted. Two quarts of a hot intra-uterine 1-4000 bichloride douche were injected. Patient rallied well, and debaring an occasional slight rise of pulse and temperature, and faintly foetid lochia, which readily yielded to the antiseptic douche, the puerperium was uneventful and recovery complete. This case was a novel one to me. I am quite sure the membrane I felt was mucus, and not the amniotic sac, nor do I think the case should be classed among those of cervical occlusion or stenosis from endotrochelitis.

DR. J. WHITRIDGE WILLIAMS read a paper on "The Induction of Premature Labor in Contracted Pelves." He pointed out that the comparative neglect of the operation in this country was due to two causes: the absence of large lying-in institutions and the consequent lack of large amounts of clinical material, and the almost total neglect of pelvic measurement.

By the term premature induction of labor one understands the artificial interruption of pregnancy at such a period that a viable child may be born; that is any period from the 28-30th week to the end of pregnancy.

Dr. W. then went into the history of the operation and showed that it was first rationally employed for this indication in England,

as the result of a conference of the eminent physicians of London in the year 1756.

Within fifty years it was quite generally employed on the continent, and soon enjoyed a popularity which caused it to be resorted to on the most trifling pretexts, and which in 1869 called forth Spiegelberg's forcible denunciation of the operation by which he showed that the mortality both of the mothers and children was nearly three times greater after the operation than if the woman went on to term. This was followed by articles by Litzmann and Dohrn, who showed that Spiegelberg had painted the picture in colors far too dark.

Litzmann showed that in moderate degrees of contraction, 8.25—7.5 cm. ( $3\frac{1}{4}$ –3 in.), the operation was indicated in the interests of the mother, as shown by a mortality of 7.4 per cent. after the operation, compared with one of 18.7 per cent. when the woman was allowed to go on to term.

Dohrn stated that the proper method of appreciating what the operation accomplished was not to compare as many cases of induced labor with so many cases of labor at term, but to compare the results of premature and spontaneous labors in the same woman; by this method he found that twice as many children were saved by inducing labor as by allowing the woman to go on to term.

Consequently they proved that the operation was indicated in properly selected cases, both in the interest of the mother and child.

The introduction of antiseptic methods into midwifery almost completely robbed the operation of danger for the mother, as will be readily seen from the following statistics: Thus, Haidlen reports forty-four cases from the Stuttgart clinic, with no maternal deaths, and 72 per cent. of the children saved.

In 1889, Korn stated that Leopold lost one woman in forty-five cases and saved 66 per cent. of the children; and last July Ahlfeld stated that he had induced labor 118 times with the loss of only one mother, and had saved 62 per cent. of the children.

At the Berlin Congress, Fehling stated that in 60 cases he had saved all the mothers and 80 per cent. of the children.

From the above sketch we will readily see that the maternal mortality in properly selected cases is very light, four hundred and one cases collected by Korn showing a maternal mortality of only 2.9 per cent., or just a trifle more than a normal labor in a normal pelvis, while the foetal mortality ranges from 20 to 70 per cent., the average being about  $33\frac{1}{3}$  per cent. So in this operation we have a means of saving about two-thirds of the children without any risk to the mother. Or reckoning by Dohrn's method we save at least twice as many children as if we allowed the woman to go on to term, and then resorted to some conservative operation. These are the prospects of the operation; unfortunately the degree of contraction within which the operation is justifiable is very limited, and we can only think of it in moderate degrees of contraction. According to Litzmann, in flattened pelvis, with a conjugata vera of 7.5–8.25 cm.; (3–3.25 in.); and to Schröder, 6.5–9.5 cm. (2.5–3.75 in.).

As pelves with a conjugata vera above  $8\frac{1}{2}$  cm. ( $3\frac{3}{8}$  in.) offer a reasonable chance to both child and mother at term, and those below 7 cm. ( $2\frac{3}{4}$  in.) offer no chance to the child, I think that the operation should be restricted to these limits; that is, between 7– $8\frac{1}{2}$  cm. ( $2\frac{3}{4}$ – $3\frac{3}{8}$  in.), in simple flattened pelves.

In the justo-minor pelvis, a conjugata of  $9\frac{1}{2}$  cm. ( $3\frac{3}{4}$  in.) or less will usually be an indication for the operation. In the rare forms of obliquely narrowed pelvis, whatever its cause, we must be guided almost entirely by the history of previous labors.

We thus have the operation restricted to a very small range— $1\frac{1}{2}$  cm. ( $\frac{5}{8}$  in.), which should only be exceeded when the previous history tells us that the previous labors have all ended disastrously. We should not think of inducing labor in a flattened pelvis with a conjugata below 7 cm. ( $2\frac{3}{4}$  in.), for in that case the prospects for the child are almost *nil*, and the danger to the mother greatly increased. Here we come to the relative indication for Cæsarean section, when it is best to allow the woman to go on to term, and attempt to save the mother and child by that operation.

With these contracted indications, we readily see that an accu-



rate idea as to the exact size and form of the pelvis is an absolute prerequisite for the performance of the operation; and the only means by which we can accurately obtain this information is by carefully measuring the pelvis.

We should not content ourselves with simply measuring the *conjugata vera*, but should also take the external measurements and thereby attempt to determine with what form of pelvis we have to deal. After doing that, we must carefully examine the interior of the pelvis to determine its height; to see if it is generally contracted, and if contracted, if the contraction increases as we approach the outlet, we must look for exostoses of the pelvic bones and carefully examine the promontory to see if it is double or not.

If we think the pelvis contracted laterally we should measure the distance between the *tubera ischiorum* on each side, as Breisky recommended. We should also attempt to estimate the transverse diameter of the pelvis, which is most difficult to do, and the most that can be expected is to examine alternately with each hand and try to stroke the *linea innominate*, and so relatively get some idea as to the transverse diameter.

Having decided that an operation is necessary the next question is, when shall it be done? Of course, the younger the *fœtus* the smaller will be its size, and consequently the easier its delivery. But unfortunately, the smaller the *fœtus*, the less chance will it have of living even if it survive the operation. Generally speaking, we say a child is viable after the 28th week, but its chances of living are almost *nil*; indeed children thirty to thirty-two weeks old have next to no chance of living. The earlier the operation, the more chance has the *fœtus* of living after it, but unfortunately its size and consequently the difficulty of its delivery increase with its age. If possible, the operation should be done about the 34th to 36th week, our object being to operate at the latest possible period consistent with safe delivery.

To fulfill this object we must attempt to gain accurate knowledge as to the size of the child's head. Unfortunately we are unable to determine its size with mathematical precision, or even with the relative precision of *pelvimetry*; so we are obliged to

take advantage of every possible hint on the subject. Some of the following points may be of assistance in different cases. We must consider the mother's account as to the duration of pregnancy. Notice the size of the parents, large parents usually having large children. Inquire about the previous labors, particularly as to the size of the head. Endeavor to estimate the size of the head by abdominal and combined abdominal and vaginal palpation; and note the consistency and amount of resistance to compression that the bones of the head offer.

Try to measure the head with the pelvimeter through the abdominal walls, and deduct the estimated thickness of the abdominal walls from the result.

Notice the size of the large anterior fontanelle, average width 2 cm.; the width of the sutures, and the distance from the anterior to the posterior fontanelle; for as they are larger or smaller, it indicates a larger or smaller head. Measure the length of the foetus as it lies *in utero*, from breech to vertex, double the measurement and it gives, according to Ahlfeld, the length of the foetus. If a foot is prolapsed, measure it, for Goenver stated that there is a difference of nearly 1 centimeter between the length of the foot of a child at term and one at thirty-two to thirty-four weeks.

One of the most important methods is that of Mueller, who attempts to force the head down into the pelvis by pressure from above. As long as he is able to force the head down, he knows that labor will readily take place; but when he can no longer force the head down and when it bulges out over the symphysis, then he considers that the time for operation has arrived. As the great danger to the mother is from sepsis, one cannot be too careful in one's efforts to guard against it, and consequently one should be most particular in one's preparation for the operation.

For several days previous to operating, the woman should have a warm bath daily; and several times a day be douched with warm water, 95° 98° F. containing salt or borax by which the cervix is softened and dilated. Just before operating, the genitals should be most carefully washed with hot water and soap,

followed by a 1-1000 bichloride solution; the vagina should also be most carefully cleaned.

The hands of the operator should be washed for at least ten minutes in hot water and the nail-brush vigorously used, after which they should be placed for several minutes in a 1-5000 bichloride solution.

All instruments should be sterilized by strain or placed in a five per cent. solution of carbolic acid for at least thirty minutes.

The most generally approved method is that of Krause or the introduction of a disinfected flexible bougie between the membranes and the uterine wall. If properly conducted it is almost entirely devoid of danger for the mother, and will bring about the birth of the child in a period varying from 8-214 hours, averaging about 80 hours or about three days. To insert the bougie, the woman is placed on her back or side as may be most convenient, and the cervix brought down by a pair of bullet-forceps and the cervical canal carefully cleansed with bichloride on a pledget of cotton; the bougie is then carefully inserted so that its lower end is within the vagina, care being taken not to wound the membranes or the placenta. Then the vagina is packed with iodoform gauze, care being taken not to wound the cervix which serves to hold the bougie in place. If at the end of twenty-four hours no labor pains have been produced, the bougie should be removed and another introduced at another point under the same precautions as the first.

If this method fail, we may resort to Kisvisch's method of allowing a current of hot water, 100°-110° F., to flow through the vagina several times a day for a period of 5-15 minutes, or we may puncture the membranes; as accessory to these, we may loosen the membranes about their lower pole, dampen the vagina with iodoform gauze or employ Barne's bags.

If the pains are weak, Fehling recommends version by Hick's method and bringing down one leg, whereby increased contraction is produced, and one is afforded a ready means of ending the labor if one deems it expedient in the interests of the mother or child.

DR. NEALE: I regard the chief point in this very able paper to

be the endeavor to definitely fix the limits for the induction of premature labor in contracted pelves, not as opposed to Cæsarean section, but as applicable to a distinct and separate class of cases. This endeavor I strongly advocate, but at the same time must confess that I do not believe the plan is always practicable at the bedside. There are so many factors entering into the determination of this question, as I stated in my paper, that I can now only repeat what I there quoted, viz.: "A given pelvic measurement is useful as an indication of what has been the experience of others under similar circumstances, but is not a final ground for decision."

After this evidence adduced, which doubtless represents the opinion of the best medical authorities, I am sure I only voice the concurrence of this society in accepting the limits for this operation as stated by Dr. Williams.

This is practically in accordance with the teachings of Lusk, probably our strongest American authority, who places the range for the induction of premature labor in contracted pelves at a conjugata vera of from  $2\frac{3}{4}$  inches (7 cm.) to  $3\frac{1}{2}$  inches (8.75 cm.)

As stated in the paper, I believe the most reliable statistics of this operation are those of Dohrn, who compares the results of induction of premature labor with those of labor of term in the same case, showing a very decided advantage in premature labor. It must be remembered, however, as Litzman has clearly shown, that children born alive by this operation are far more likely to die early than matured children. The risk to the child does not cease with the delivery.

I cannot recall any reference in the paper to pelves contracted from hip disease, and yet I have met with two obstetrical cases of this character during the past two years in this city; both were in private practice, and both were primiparæ.

The first case I saw in consultation during a very severe labor at term, and delivered her of a still born child by a difficult high (Tarnier) forceps operation.

Premature labor was induced on the second case at the eighth month. In this case the bougie was retained under antiseptic

precautions (2 p. c. creoline cervical and vaginal douche and iodoform gauze over os) between the membranes and uterine walls for 48 hours without effect. It was then withdrawn, the douche again administered, and bougie reintroduced in a different position and retained for 24 hours again without effect. The sac was then punctured high up by the probe, and labor began in about 15 hours. Thus we see the method of Krause, although the best, may fail, where puncture of the sac will not.

As this lady was poisoned to death by an unclean servant who dressed and picked carious bone from her foot and then attended my patient, and handled all her linen, napkins, etc., without my knowledge, it shows the importance of extending our antiseptic precautions to everything coming in personal contact with the case.

As regards the method of delivery, the experiments of Budin and others speak strongly in favor of version and extraction as opposed to forceps.

DR. KELLY: The subject is too large to be discussed formally. I will merely refer to one or two points of interest. A serious complaint is to be entered against the records of foreigners in regard to the statistics of infant mortality after premature labor. Many observers only state whether the child was born living or dead; some few state whether or not it was living when discharged from the hospital. What we want to know for practical purposes, is whether the children live any time after they get home. My own experience is but few live. If they are sent out simply to die soon after at home, the induction of premature labor among the poorer classes simply becomes a species of uterine gymnastics.

A method of my own, which I have found most successful in inducing premature labor, is taking a flexible whalebone bougie, introducing it between the membranes and the uterine wall, high up into the uterus, and sweeping it gently around for one or two inches in either direction. This has not failed me in any instance in bringing on labor.

WILLIAM S. GARDNER, M. D.,  
Secretary.

410 Hanover St.

## Correspondence.

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### OUR NEW YORK LETTER.

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NEW YORK, April 15, 1891.

This city has again been invaded by la grippe, which we hoped to have seen the last of a year ago. During the past few weeks the death rate here, in Brooklyn, and in several other northern cities has been markedly increased. The clinical history of the disease has varied in some respects from that of last year. Intense pain in the frontal region, with almost complete obstruction of the nasal passages was a prominent feature of many of the early cases; at present there is a decided tendency to the development of pneumonia, which is often of a peculiar, transient type. Nothing new has yet been discovered regarding the real nature of the disease, nor can it be said that any uniformly satisfactory treatment has been established.

#### THE TREATMENT OF LUPUS.

At the last meeting of the Academy, this was the subject under consideration. The paper of the evening was read by Dr. Piffard, the well-known dermatologist. He stated that at one time lupus was confounded with cancer. It was then regarded as a manifestation of scrofula, and now it was believed to be a local tuberculosis. Many varieties of treatment had been recommended since the earliest times. The induction of a severe local inflammation by the application of an irritant was a method long in vogue. Biniodide of mercury was the agent usually employed; but the remedy was liable to cause injury, and generally proved too mild a stimulant, so that its use had been discarded. Boring with a sharp point of silver nitrate was still resorted to by many; but it was inefficient, as many outlying cells were sure to escape. Absolute destruction of every particle of diseased tissue

was essential to the production of a cure. Excision, if practicable, would seem to promise the best results. It could only be employed, however, when the disease was distinctly circumscribed, and not more than an inch or so in diameter. Relapse was more frequent than after operations for epithelioma, as it was more difficult to remove every diseased point. Treatment by the actual cautery alone was seldom employed, and was not often successful. Curetting alone was also unsatisfactory. A combination of curetting and the cautery was, however, about as valuable a plan of treatment known. The cautery should be heated to redness only. A useful procedure was scarification with a platinum knife heated to redness by means of electricity. Repeated operations were usually necessary. An anæsthetic was not always required; in any case ether must not be used, because of the danger of explosion; nitrous oxide gas and opium answered every purpose.

In regard to the Koch treatment, it might be said that the statements of its originator had not been verified. Many men not especially familiar with skin diseases had discharged cases of lupus as "cured." To the eye of the specialist, however, they did not appear so, for the significant apple jelly granules could always be detected either immediately, or very soon after treatment had been discontinued. The cicatrix must appear completely colorless and blanched before it could be pronounced healthy. The action of Koch's fluid was certainly unique. It was unlike the action of such poisons as arsenic, strychnine, or atropine, which was similar in the sick and the well. It was more like that of erysipelas or typhoid fever.

Dr. H. N. Heineman said that of the nine cases treated by the Koch method at Mt. Sinai Hospital, two had been pronounced cured, no relapse being noticeable seven weeks after treatment was discontinued. He believed that a combination of local and injection treatment would eventually prove of most value.

Dr. H. P. Loomis gave an account of a few cases treated at Bellevue Hospital. Of these only one was cured. Another, which was very severe, was improved so much after a short

course of treatment, as to demonstrate very conclusively the great value of the remedy. Stereopticon views of these patients were exhibited, showing the different stages of the improvement under the action of the tuberculin. The most striking case was one of a very extensive lupus of the face and neck. After a short course of treatment, all the active ulceration ceased, and the general aspect of the disease was greatly changed.

Dr. R. W. Taylor did not think that the bacillary origin of lupus had been proven, nor had its association with pulmonary phthisis been generally noticed.

Dr. G. H. Fox was not in favor of treating any case by excision. He liked the curette better. The actual cautery or galvano-cautery was not so satisfactory as the potential caustics, which had a selective action. The curette and some agent producing suppurative inflammation, produced the most satisfactory results. He drew attention to the dental burr as a most effective instrument for destroying isolated tubercles. He had seen a number of cases treated by the Koch method, and regarded it as extremely valuable.

#### PREVENTION OF DIPHTHERIA.

The subject of diphtheria was again under consideration at the last meeting of the Academy Section in Pædiatrics, with especial regard to the question of prevention. Dr. A. Caillè, the chairman, opened the discussion. He stated that, during the year 1890, there had been 1,400 deaths from the disease in New York alone. He thought that much could be done to protect well children from contracting it. The early treatment of a naso-pharyngeal catarrh, and thorough cleansing of the mouth and teeth at all times, were points never to be neglected. He believed that the daily inspection of school children by physicians appointed by the city, was quite practicable, and would be the means of saving many lives.

Dr. J. Lewis Smith said that Welch, of Baltimore, had induced diphtheria in animals with cultures of the Klebs-Löffler bacillus. It could now be positively believed that this was the specific organism of the disease. The germ was possessed with mar-



vellous vitality and could be conveyed in many different ways. Exposure in the room or to the breath of a sick person was often sufficient. The clothing of nurses of children who had been sick, or of physicians who, on examination of a throat, had been spattered with sputum, might be the vehicle of contagion. There were many walking cases, and the schools were often the means of bringing them in contact with the healthy. Prior to 1850, diphtheria did not prevail in New York. It then appeared, and the sewers became infected. Thus it happened that sewer gas produced the disease, and with the walking cases was the origin of most of the cases occurring here.

When a case developed in a family, all furniture which could be spared should be removed from the sick room, and only those engaged in caring for the patient should be permitted to enter. Ventilation should be carefully attended to, and the air of the room should be permeated by some antiseptic vapor. The convalescent patient should be carefully disinfected, and kept apart from other children at least a month. In the after disinfection of the room sulphur fumigation should be used, but was not entirely reliable. In addition all surfaces should be washed with corrosive sublimate solution.

Dr. Prudden, the pathologist, believed that it had become possible to make a diagnosis of diphtheria by means of biological cultures of the bacilli found. He advised the use of mild antiseptic mouth washes as a preventive measure.

Dr. Jacobi drew attention to the appalling fact that 40,000 children had died from diphtheria in this city alone during the past thirty years. In the face of such a fact the indifference of the public as compared with the excitement apparent in the press over a single case of typhus fever in Bellevue Hospital was astounding. One of the greatest necessities was a temporary home to which the well children of the poor could be taken when a contagious disease had invaded the home. The teachers of public schools should be taught to examine children's throats, and all suspected cases should be sent home.

Dr. L. Emmett Holt said that during the past four or five years there had not been an epidemic of diphtheria at the New

York Infant Asylum. There were four hundred infants at this institution nearly all under two years old, and more than half less than eighteen months. Sporadic cases appeared occasionally. As soon as they were observed each was isolated separately, and the ward from which they were taken was emptied. After fumigation with sulphur, all surfaces were washed with corrosive sublimate solution, and the iron bedsteads with a solution of carbolic acid. The throats of children who had been exposed were examined twice daily, and their nasal cavities syringed with 1 to 5000 bichloride solution.

#### CRANIOTOMY *versus* CÆSAREAN SECTION.

Is embryotomy of the living fœtus ever justifiable? This was the question under discussion at the last meeting of the Section on Obstetrics at the Academy. Dr. E. H. Grandin read a paper advocating elective Cæsarean section. He believed that with a better knowledge of pelvimetry, and with the great improvements which have been of late years made in the operations, a deliberate choice of Cæsarean section would soon become the rule in cases in which the exact condition of affairs had been ascertained before other methods of delivery had been attempted and had failed. He thought the statistics of the operation misleading, as the majority of cases had been operated upon only as a last resort.

Dr. H. J. Garrigues was of the opinion that even with the improved Cæsarean section, the operation was more fatal to the mother than craniotomy. The chances of saving the mother after craniotomy were five times greater than after Cæsarean section. In certain exceptional cases the latter operation might be deliberately selected, as when the pelvis was generally contracted, rendering extraction of the child after craniotomy exceedingly difficult. As a rule, however, it was better to destroy the child. This was especially true in private practice. The operation of Cæsarean section requires skilled assistance and a qualified abdominal surgeon.

Dr. Lusk said that he agreed thoroughly with the remarks of Dr. Garrigues. We had no moral right to balance one life against another, and decide to kill one human being to save an-

other. His custom was to put the question to the mother and friends, stating without exaggerations the dangers of the different operations, and allow them to decide if they cared to take the extra risk involved in Cæsarean section. The chances of the mother were certainly not so good. In those hospitals in which the mortality from Cæsarean section had been so much reduced, that from craniotomy was almost nothing. The operations could not be compared with an ordinary laparotomy, for the conditions were different. A number of skilled assistants were necessary, while to do a craniotomy one skilled operator was all required.

#### A QUESTION IN ETHICS.

At the last meeting of the County Society an interesting discussion occurred over the question of the propriety of physicians allowing themselves to be interviewed by newspaper reporters. Dr. F. R. Sturgis introduced the subject, and took the ground that on matters pertaining to public health, or prominent new methods of treatment, or unusual surgical operations, physicians were justified in responding to the request of newspaper men for an expression of opinion.

Dr. Shrady, editor of the *Medical Record*, believed that when a physician could feel that he was called upon as the spokesman of his profession in conveying to the public useful information, he was perfectly justified in speaking. When, however, he magnified his own acts, and the *ego* appeared in every sentence, it would be better for him and for the profession if he had not spoken.

WM. L. RUSSELL.

151 East 50th Street.

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PROF. WILLIAM ROSE, of London, recently removed the superior maxillary bone and excised the Gasserian ganglion for severe *tic douloureux*. This is said to be the only instance in which this operation has been done. The patient's eye was lost on the affected side, but the neuralgia ceased. *Gaillard's Medical Journal*.

## Editorial.

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### THE ANNUAL MEETING OF THE MEDICAL ASSOCIATION OF GEORGIA.

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To the few members of the Medical Association of Georgia who are in the habit of regularly attending its meetings year after year, a striking feature lies in the almost complete change in the *personnel* of these gatherings, as they successively occur in different parts of the State. The members who were present in Rome, and who made that meeting one which will long be remembered in the history of the Association, were conspicuous chiefly by their absence at the meetings in Macon and Brunswick, while those who contributed to the eminent success of the Association when it met in the latter cities were sought in vain last month in Augusta. This fact has been urged as a reason for the permanent location of the Association in one of the central cities of the State, Atlanta or Macon. But to our mind it furnishes an argument against the adoption of such a course. It is the policy of the Association, or should be, to bring within its sheltering arms every regular physician in the State. A permanent location in one city would exclude from attendance, if not from membership, many practitioners in remote sections who would not wish to make the sacrifice involved in a long journey. Membership would gradually become limited to residents of the vicinity of the place of meeting until the Association would finally be practically converted into a local organization. That this danger is not a fanciful one is shown by the well-known history of the old Georgia Medical Society.

For this reason it is gratifying to know that the Association will meet next year in Columbus. It is ten years since a meeting has occurred in southwest Georgia, and consequently the membership from that section is smaller than from any other portion of the State. It is to be hoped that the presence of the Association will act as a stimulus and that large accessions to membership will result.

The recent meeting in Augusta was a successful one. A number of valuable papers were read, and the discussions which followed were animated and instructive. The society was increased by the addition of more than fifty new members. The Association was entertained with Augusta's proverbial hospitality, and every member was made to feel that a hearty welcome was accorded him.

The remarkable increase in membership at this meeting was due to the admirable course adopted by the secretary, Dr. K. P. Moore, in sending out invitations to every regular physician in the State to be present in Augusta, and to apply for membership. Dr. Moore has worked untiringly for the interest of the Association during his term of office, and deserves the highest praise for the success which has attended his endeavors.

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## OFFICIAL REPORT OF THE RESULTS OF KOCH'S TREATMENT.

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The official report on the results of Koch's treatment in Prussian hospitals has been published in *Klinisches Jahrbuch*, in which it is stated that out of a total number of 1061 patients treated for tuberculosis of internal organs 13 were cured, 194 improved, 171 substantially improved, 586 unimproved, and 46

died. In external tuberculosis (lupus, scrofula, tubercular joints, etc.) 708 cases were treated; of these 15 were cured, 237 improved, 148 substantially improved, 298 unimproved, and 9 died.

We must confess that this report, which seems to have been made in all candor, is not at all encouraging. Under our old methods of treatment we can obtain some cures and many improvements. The new method does not seem to have accomplished very much more.

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### MEETING OF THE NATIONAL ASSOCIATION OF RAILWAY SURGEONS.

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At the Kansas City meeting of the National Association of Railway Surgeons last year, it was decided to hold the next meeting at Buffalo, N. Y., May 7th, 8th and 9th of this year. But, on account of the meeting of the American Medical Association being set for the same time, it has been decided to change those dates, and to hold our next meeting at Buffalo April 30th and May 1st and 2d, to which all railway surgeons are cordially invited. To all railway surgeons sending their names and addresses to the corresponding secretary, a copy of the constitution and programme will be sent. All those wishing to read papers should send in the titles of their papers without delay. For further information inquire of

A. G. GUNMAER,  
Corresponding Secretary,  
Buffalo, N. Y.

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CONGRESS OF AMERICAN PHYSICIANS AND SURGEONS.—The meeting of the Congress of American Physicians and Surgeons will be held in Washington from 3 to 6 P. M., September 22d, 23d, 24th and 25th, 1891. William Pepper, Chairman of the Executive Committee.

## Selections.

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MARRIAGE AND CHRONIC GONORRHŒA.—Dr. G. E. Brown, of New York, presents a valuable paper on this subject in the *International Journal of Surgery* for February. Concerning syphilis and marriage, he says, a great deal has been said, and he is surprised that even in recent works gonorrhœa, in its matrimonial relations, should receive so little attention. The opinion is widely held now that far more suffering and incurable disease in women can be attributed to gonorrhœal than to syphilitic infection.

It has not infrequently been my experience to be consulted by young men, a few weeks or months before contemplated marriage, with a history of one or more attacks of gonorrhœa in former years, who believe themselves to be well; yet who, upon a careful examination, present the unmistakable signs of a chronic urethritis.

The only evidence of disease remaining in these cases may be, and frequently is, the presence in the urine of small, thread-like bodies, to which the name of *tripper faden* has been given by the German surgeons who first described them and demonstrated their importance. These minute shreds are composed of mucus, pus and epithelium, and represent the secretions which adhere to any granular patch or area of chronic inflammation remaining on the urethral mucous membrane.

Noeggerath concludes that a man who has once been the subject of a gonorrhœal urethritis never fully recovers; that the disease lingers in the glands and ducts emptying into the canal, and may at any time furnish a secretion which may infect those with whom he has sexual relations. He also states that nine-tenths of all women married to men who have had gonorrhœa, sooner or later become the subject of incurable and painful inflammatory disease of the uterus, tubes or ovaries; that this in-

fection may take place rapidly, and manifest itself as an acute infection, or by means of a slow and unrecognized process to which he gives the name of "latent gonorrhœa." He further adds that 90 per cent. of all cases of sterility can be directly traced to gonorrhœa.

Ernest Finger states, regarding marriage, that it should be absolutely prohibited in all cases where the existence of a chronic urethritis is evidenced by the presence of the "morning drop" or *tripper faden* in the urine, until the following facts have been established :

1. That after from two to four weeks of daily observation, the secretions from the urethra are found to be *free from pus and made up wholly of epithelial cells.*

2. That no gonococci can be detected by the microscope, even after a purulent discharge has been established by the employment of irritating injections of corrosive sublimate or nitrate of silver.

3. That neither prostatitis nor stricture exists.

Dr. Brewer then recites a case in his own experience which presented the above matrimonial contraindications. Against his advice and warning the young man married. Consequently, in two weeks time he saw the young wife with a purulent urethritis and vulvitis, pus showing abundant colonies of gonococci. A severe cystitis followed, a large utero-vaginal abscess which was opened under ether ; also a marked pyelitis which continued for months.

In reviewing the records of nearly one thousand cases of urethritis treated by me during the past five years I find that in six instances I was consulted regarding the propriety of marriage, under circumstances similar to those which existed in the case reported above. My rule had always been in such cases never to allow marriage until at least three months had elapsed since the cessation of all acute symptoms, and until repeated examinations of the secretions (including the *tripper faden*) had failed to show the presence of gonococci. In the six cases referred to



these conditions were observed, and in no instance has the wife exhibited the slightest evidence of infection.

In conclusion, allow me to urge upon all interested in this subject the necessity of unusual care in examinations undertaken with a view to forming an opinion regarding the propriety of marriage in those who have been the subject of gonorrhœal urethritis. The safest method would be to follow the advice of Finger as quoted above. Certainly, no one should assume the responsibility of sanctioning a marriage, without at least imposing the conditions which it has been my custom to insist upon.

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THE USELESSNESS OF SPLINTS IN FRACTURE OF THE LOWER END OF THE RADIUS.—In an article on this subject (*Medical News*) Dr. John B. Roberts, Philadelphia, maintains that the use of splints is not at all necessary in the treatment of Colles' fracture of the radius. The treatment of these fractures is exceedingly satisfactory; the results obtained are usually good, both in rapidity of cure and perfect restoration of function.

The usual cause of the injury is forced extension of the radio-carpal joint, which produces a transverse disruption through the lower end of the radius from three-eighths to one-half an inch above the articular surface. The characteristic deformity is caused by the fracturing force driving the lower fragment upward and backward upon the shaft, or thrusting the shaft downward and under that fragment, so that it is caught or impacted upon the dorsal edge of the shaft-fragment. Occasionally there is a tendency to lateral or antero-posterior obliquity of the line of fracture, but this is rather uncommon. Sometimes comminution of the lower fragment takes place so that lines of fracture enter the radio-carpal joint. The ligaments and cartilages are sometimes extensively injured, and sometimes there occurs actual loss of substance by crushing and pulverizing of the bone tissue. These complications, except that of comminution, are quite rare.

Reduction of the fracture, the most important element in the treatment of the injury, is often ineffectually accomplished, or, indeed, not attempted. This is owing to ignorance rather than

carelessness on the part of the attendant. When reduction is once thoroughly accomplished, displacement is not apt to recur, because the broad rough surfaces of bone are held together by their serrations, and because there are no muscular masses tending to displace the fragments.

The condition, it will be observed, is quite different from oblique fracture of the shaft of a bone, in which it is often difficult to maintain accurate apposition because of the muscular displacing forces. Hence if reduction, which is the essential in treatment, is properly performed, no splint is needed. On the other hand, if reduction is neglected, no splint will act as a substitute for it. If reduction has been properly accomplished, an improper splint may displace the lower fragment and cause recurrence of the deformity. Hence, abandonment of splints is usually the proper course to pursue, and probably the most judicious method of treatment to advocate and teach.

Comminuted fractures, of course, need more support than do non-comminuted ones ; but even here, the simple support of a bandage applied in a circular manner, or of strips of adhesive plaster wound around the wrist like a collar will usually be found sufficient.

At the present time I should be inclined in nearly all cases to treat the fracture without using any splint at all ; or, at most, I should employ only a thin strip of steel or zinc, or a couple of pieces of whalebone, six inches long, applied to the dorsum of the wrist, and held in place by strips of adhesive plaster. I am now convinced that a roller bandage or a strip of adhesive plaster applied to the wrist in a circular manner is all that is necessary, except in unusually complicated fractures. All ordinary forms of splints should, as a rule, be discarded as useless or dangerous.

The proper treatment of fracture of the lower end of the radius is *reduction*. Little else is required in the ordinary cases.

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NEW METHODS OF TREATMENT IN TYPHOID FEVER.—  
Dujardin Beaumetz (*Bullet. Gen. de Theraput.*) studies

prophylaxis of typhoid fever, and the use of cold baths, intestinal antiseptics, and diuresis in the treatment of the disease.

Prophylaxis has been more benefited than was treatment by the discovery of the bacillus of Eberth. Rigorous care of typhoid patients is insisted upon ; a strong solution of copper sulphate, twelve drachms to the quart, is recommended for washing sheets, etc. ; a weaker solution, three drachms to the quart, is used to disinfect the nurses hands, etc. For intestinal antiseptics salol is preferable to iodoform, naphthol, naphthaline, etc., being less harmful and more efficient. Thirty to sixty grains may be given in twenty-four hours, in combination with salicylate of bismuth, if the drug is indicated.

Hyperexia is not an essential part of the general condition of the disease. The case may be serious without it. Antipyretic drugs decrease urinary secretion, and retard the elimination of the poisons produced. The author finds that in sponging, enveloping in wet sheets and tepid baths, he has all the advantages of cold baths without their inconveniences. He treats cases symptomatically. Beginning with sponging, he gives tepid baths (86°-89° F.) ; if the temperature passes 104° F., one or two a day, lasting twenty to thirty minutes. Stimulating drinks are given to patients, if needed, while in the bath.

Quinine is regarded as the drug best able to met the general indications of typhoid, not more than fifteen grains a day being given. The kidneys are the best agents for the elimination of waste products. He gives abundant drinks, preferably lemonade made with wine, to favor diuresis.

In studying the influence of the treatment on mortality, he finds that the difference under the various methods is slight ; in 1889, under symptomatic treatment, there was a mortality in Paris hospitals of 11.33 per cent. ; by systematized treatment with cold baths, the mortality was 11.28 per cent. The lowest mortality for the year, 7.33 per cent., was obtained by the combined use of quinine and tepid baths.—*University Medical Magazine*, March, 1891.

**ELECTRICITY IN GYNECOLOGY.**—Apostoli (*Proceedings International Medical Congress, 1890*) states the following as his present views on the subject:

1. The principal value of the constant current is in its action in cases of fibroid tumors and endometritis, especially where pain and hemorrhage are constant symptoms. It not only arrests the growth of benignant tumors, but promotes the absorption of peri-uterine exudations, contraindicated in acute suppurative inflammation of the adnexa.

2. The galvanic current possesses a polar and an interpolar action, the latter being of a trophic and dynamic character, the former thermic and antiseptic.

3. The more powerful currents (above fifty milliamperes) influence the circulation through the development of heat. They are antiseptic and germicidal. They can be easily employed by the general profession. The stronger the current employed, the less the probability of a return of the symptoms.

4. Intra-uterine galvanization is preferable, because by it the maximum effect is obtained, the antiseptic action of the positive pole is secured, direct cauterization is effected, and there is less pain than in the intra-vaginal method.

5. In proper cases galvano-puncture by means of a fine gold needle, insulated to within one-fifth of an inch of its point, enables the operator to concentrate the action better and to produce a more powerful effect with weak currents.

6. As compared with the application of caustics and curetting, intra-uterine galvanization is far more harmless, as shown by the writer's experience, who, between July, 1882, and July, 1890, had practiced the latter 11,499 times with only three fatal results. One of these was a case of galvano-puncture for subperitoneal fibroma; another, the same for salpingo-oöphoritis; and in the other the same treatment was employed in an ovarian cyst which was mistaken for a fibroid.

In thirty instances pregnancy followed the use of intra-uterine applications.—*American Journal of Medical Sciences.*

FIRST ANNUAL REPORT OF THE NEW YORK PASTEUR INSTITUTE.—Eight hundred and twenty-eight persons, having been bitten by dogs or cats, came to be treated. These patients may be divided in two categories :

1st. For 643 of these persons it was demonstrated that the animals which attacked them were not mad. Consequently the patients were sent back after having had their wounds attended, during the proper length of time, when it was necessary.

2d. In 185 cases the anti-hydrophobic treatment was applied, hydrophobia of the animals which inflicted bites having been evidenced clinically, or by the inoculation in the laboratory, and in many cases by the death of some other persons or animals bitten by the same dogs. No death caused by hydrophobia has been reported among the persons inoculated.

Indigents have been treated free of charge.

The persons treated were : Eighty-one from New York, twenty-seven from New Jersey, sixteen from Massachusetts, eleven from Connecticut, nine from Illinois, five from Georgia, five from North Carolina, five from Pennsylvania, three from Maryland, three from Missouri, two from New Hampshire, two from Texas, two from Kentucky, two from Ohio, one from Maine, one from Arizona, one from Minnesota, one from Iowa, one from South Carolina, one from Nebraska, one from Rhode Island, one from Arkansas, one from Virginia, one from Louisiana, one from Indian Territory, one from Ontario, Canada.

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DISEASES OF NORTHERN CALIFORNIA INDIANS.—Lieut. Charles E. Woodruff, M. D., U. S. A. (*Medical Record*, January 24); gives his experience and observations on certain diseases, particularly phthisis, among the Western Indians. It is not certainly known, he says, whether the disease prevailed before the advent of the white man. Nevertheless at the present time consumption is exceedingly prevalent and fatal among them. During a short residence among them of one year and a-half he has seen whole families wiped out of existence. It is among the half-breeds, white father and Indian mother, that the greatest mortality is found.

The changes wrought by the whites are certainly to some degree responsible for the increased prevalence. Formerly, while naked, he was inured to cold; would wade through mud and water with impunity, for in a few minutes his naked feet and legs would be dry again. Now, when clothed and shod, he does the same thing, but he has not learned to change his clothing, and will stand idly around until he dries. They crowd together in their rooms for warmth, and a consumptive among them has every facility for spreading the disease.

The children that are taken in white families and raised as servants, though originally possessed of vigorous health, after some years of civilization under the best conditions, fall into consumption and promptly die.

Syphilis and gonorrhœa are also exceedingly common. Syphilis and phthisis are probably responsible for the smallness of their families. Mortality of infants is large. The Indian seems to afford a natural culture ground for gonorrhœa. There is scarcely a squaw under sixty who has not had it, and the men accept it as a matter of course.

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STRICTURE OF THE URETHRA—THE *University Medical Magazine* for March prints a valuable paper on Stricture of the Male Urethra, by Dr. J. William White, which concludes as follows:

1. Strictures of large calibre, that is, of more than 15 French, situated at or behind the bulbo-membranous urethra, are to be treated, almost without exception, by gradual dilatation.

2. Strictures of large calibre occupying the pendulous urethra are to be treated by gradual dilatation when very recent and soft, and by internal urethrotomy when of longer standing, distinctly fibrous in character or non-dilatable. It is to be remembered that the great majority of so-called strictures of large calibre of the pendulous urethra are merely points of physiological narrowing.

3. Strictures of the meatus and of the neighborhood of the fossa navicularis should be divided upon the floor of the urethra whenever it is evident that they are real pathological conditions

producing definite symptoms, and not normal points of narrowing.

4. Strictures of small calibre (less than 15 French), situated in advance of the bulbo-membranous junction, unless seen very early and found to be unusually soft and dilatable, furnish the typical condition for internal urethrotomy, which should be done preferably with a dilating urethrotome and, invariably, with all possible antiseptic precautions.

5. Strictures of small calibre (less than 15 French), situated at, or deeper than, the bulbo-membranous junction, should be treated whenever possible by gradual dilatation. In a case of resilient, irritable or traumatic stricture in this region, or of stricture which, for any reason (as the occurrence of rigors), is non-dilatable, external perineal urethrotomy is the operation of choice.

6. Strictures of the deep urethra, permeable only to filiform bougies, should be treated by gradual dilatation when possible, the filiform being left *in situ* for some time, and followed by the introduction of others, or used as a guide for a tunnelled catheter. If the stricture be not suitable for dilation, external perineal urethrotomy should be performed.

7. Impassable strictures of the deep urethra always require the performance of perineal section.

**TREATMENT OF WHOOPING-COUGH.**—The following treatment is used very largely by certain leading specialists in diseases of children in Paris. The treatment is divided into three periods. The patient should remain in one room or bed. The following prescription is given:

R.	Tincture of aconite, . . . . .	} Of each 1 drachm.
	Tincture of belladonna, . . . .	
	Camphorated tinct. opium, . .	

M. Sig.—Two to five drops once or twice a day, according to the age of the child.

If there is no febrile movement the amount of aconite may be much decreased, and if constipation is present the opium should

not be used. In the second period, or when vomiting comes on, ipecac may be given in small amounts to allay gastric irritation, and in the third period, when convalescence is established, cod liver oil, tonics and Fowler's solution will be found of service.—*Medical News.*

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**TREATMENT OF CHOLERA INFANTUM.**—In *Therapeutic Gazette* (Nov. 15, '90) Dr. L. G. Broughton, of Reidsville, N. C., recommends the following mixture in severe cases of cholera infantum, with profuse and watery stools :

℞. Salicylate of bismuth, . . . . 2 drachms.  
 Sulpho-carbolate of zinc, . . . 4 grains.  
 Chalk mixture, . . . . . 1 ounce.  
 Paregoric,                    }  
 Water,                        } of each, . . . ½ ounce.

M. Sig.—One drachm every two hours until bowels are controlled.

Then the following is given:

℞. Calomel, . . . . . 1 grain.  
 Sulpho-carbolate of sodium, . . 20 grains.  
 Saccharated pepsin, . . . . . 19 grains.

Divide in ten powders, and give one every three hours. If the stomach is not irritable, sulpho-carbolate of zinc is substituted for the sodium salt in the last prescription.—*Gaillard's Medical Journal.*

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**LOCAL ANÆSTHESIA FOR SLIGHT OPERATIONS.**—For operations upon small abscesses, opening fistulous tracts, or removing superficial growths, it is recommended that local anæsthesia be secured by following spray :

℞. Chloroform, . . . . . 10 parts.  
 Ether (sulphuric), . . . 15 parts.  
 Menthol, . . . . . 1 part.

M.

The anæsthesia thus obtained lasts from two to ten minutes.—*Medical News.*



**THE INUNCTION METHOD IN SYPHILIS.**—The plan of treatment employed by LELOIR, of Lille (*Uni. Med. Magazine*), is as follows: The initial lesion is treated with applications of a mercurial preparation. Constitutional treatment, which is withheld until secondary symptoms appear, consists of daily inunctions of from thirty to sixty grains of mercurial ointment, and the first course is continued for a period of from six to ten months. An interval of freedom from treatment for three weeks to two months is then allowed, and the inunctions are again instituted and kept up until the end of the second year. To prevent the accumulation of the drug, a diaphoretic or a laxative is occasionally given; and in the exceptional cases in which headache or bone pains are severe, iodide of potassium in combination with the bromide is prescribed. After the end of the second year, the course depends upon the severity of the case. If symptoms have been absent for a long period, the inunctions are made every three months for ten days, and then the iodide of potassium is exhibited for several weeks, in doses of from thirty to forty-five grains daily. After the third or fourth year, if there has been absence of symptoms for one year, the inunctions are made twice a year for ten days, and followed by a course of the iodide as before. This plan is continued if the patient is seen after the fourth year.

Leloir avoids the internal administration of mercury, on the ground that it may give rise to unfavorable symptoms, and employs it only when there is some reason why the inunctions cannot be practiced. Hypodermic injection of mercurial preparations he seldom resorts to, and then only in hospital patients.

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**INTRA-UTERINE TAMPON FOR POST-PARTUM HEMORRHAGE.**—Auvard (*Archiv de Tocologie*, December, 1890) considers Duehrsen's plan of treating post-partum hemorrhage by an intra-uterine tampon of iodoform gauze a safe and reliable treatment. He finds the mortality in sixty-seven cases about 6 per cent.

The method of applying the tampon is as follows: The anterior and posterior lips of the cervix are transfixed and drawn

downward with tenacula, and a strip of iodoform gauze carried by means of dressing forceps to the fundus. The other hand is placed on the fundus through the abdominal wall, while the cavity of the uterus is being filled with the gauze. The tenacula are removed, and the end of the gauze is left at the vulvar opening. The tampon should be removed in from twelve to twenty-four hours. He considers two grades of post-partum hemorrhage—viz., bleeding of moderate severity, and hemorrhage—alarmingly profuse.

In the former variety the loss of blood may be due to uterine inertia, wounds of the vulva, vagina or cervix; and the treatment of these milder cases should include, besides ligatures and sutures, antiseptic injections of hot water, the administration of ergot and the application of the utero-vaginal tampon. When the loss of blood is alarming, uterine inertia is the cause. The bleeding should be controlled by compression and massage of the uterus through the abdominal wall, by the introduction of the hand into the uterus to remove its contents, followed by the utero-vaginal tampon.—*Univ. Med. Magazine.*

**TREATMENT OF DIPHTHERIA.**—Following is the London Hospital formula:

R. Ferri chloridi..... 6 drachms.  
 Potassii chloratis.....40 grains.  
 Glycerini..... 4 drachms.  
 Aquæ q. s. ad..... 8 ounces.

Ft. Solutio. Sig. One-half to one teaspoonful every hour.—*Brit. Medical Journal.*

**A MIXTURE FOR COLIC.**—Dujardin-Beaumetz recommends the following mixture in the treatment of simple colic:

R. Strong chloroform water.....4 ounces.  
 Decoction of orange flowers.....4 ounces.  
 Tincture of capsicum.....2 drachms.

M. Sig. A dessertspoonful every 15 minutes until relieved.—*Medical News.*

## MEDICAL ITEMS.

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IN the University of Pennsylvania the compulsory course for the medical degree has been lengthened to four years.

THE medical faculty of the University of Bonn has abandoned the use of both Koch's and Liebreich's "remedies" for tuberculosis.—*Medical Record*.

THE 38th annual meeting of the North Carolina State Medical Society will be held in Asheville May 26th, 27th and 28th. Subject for debate, "Appendicitis." Leader of debate, W. C. Galloway, M. D.

THE latest remedy for pulmonary consumption is that recently announced by Prof. Liebreich, of Berlin. It consists of Spanish fly in the form of the cantharidinate of potash subcutaneously. Surprisingly good results are obtained, particularly in tuberculosis of the larynx.

BLACK EYE.—There is nothing to compare with a tincture or a strong infusion of capsicum annuum, mixed with an equal bulk of mucilage of gum arabic, and with the addition of a few drops of glycerine. This should be painted all over the bruised surface with a camel's hair pencil, and allowed to dry, a second or third coat being applied as soon as the first is dry. If done as soon as the injury is inflicted this treatment will prevent the blackening of the bruised tissues. The same remedy has no equal in rheumatic, sore or stiff neck.—*Medical Times, Weekly Medical Review*.

A PLEA FOR CIRCUMCISION.—It is surely not needful to seek any recondite motive for the origin of the practice of circumcision. No one who has seen the superior cleanliness of a Hebrew penis can have avoided a very strong impression in favor of the removal of the fore-skin. It constitutes a harbor for filth, and is a constant source of irritation. It conduces to masturbation, and adds to the difficulties of sexual continence. It increases

the risk of syphilis in early life, and cancer in the aged. I have never seen cancer of the penis in a Jew, and chancres are rare.  
—*Jonathan Hutchinson.*

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J. P. Lippincott Company will, beginning with April, issue quarterly thereafter a work entitled "International Clinics." This work will comprise the best and most practical clinical lectures on medicine, surgery, gynæcology, pediatrics, dermatology, laryngology, ophthalmology and otology, delivered in the leading medical colleges of this country, Great Britain and Canada. These lectures have been reported by competent medical stenographers and thoroughly revised by the professors and lecturers themselves. The object of the work is to furnish the busy practitioner and medical student with the best and most practical clinical instruction, in concise form. Each volume will consist of over 350 octavo pages, illustrated with photographic reproductions of important cases.

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THE Illinois State Board of Health has recently refused longer to admit foreign physicians to practice in that State without undergoing the usual examination. This action was taken because:

1. The diplomas of medical schools and universities do not entitle the holders to practice in those countries.
2. As may be seen from p. viii of the "Report on Medical Education" of the Illinois State Board of Health for 1891, the Prussian Staats Examer Commission rejected in 1890 more than 40 per cent. of the graduates of the University of Berlin, more than 47 per cent. of the Breslau graduates, more than 31 per cent. of the Griefswald and Halle graduates, and in fact more than 29 per cent. of the university graduates that came before the commission.
3. Many of the rejected candidates come to this country.
4. Many such graduates, fearful of failing in the government examinations in their own countries, come to this country to enjoy a privilege denied them at home of practicing medicine simply on their diplomas.
5. The Illinois State Board of Health feels that it should not place upon diplomas a higher valuation than is given to them in the countries in which they are granted.

—*Jour. Am. Med. Ass.—Weekly Med. Review.*

## Book Reviews.

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ESSENTIALS OF PRACTICE OF MEDICINE. BY HENRY MORRIS  
M. D., late Demonstrator Jefferson Medical College, Philadelphia, etc. Philadelphia. W. B. Saunders.

The "Essentials" and "Compends" seem to have come to stay, and doubtless accomplish a certain purpose. The present one is designed especially for the advanced student of medicine and for the young practitioner, and for its size certainly seems to cover the ground remarkably well. Students, we believe, will find the book useful. Necessarily there are important omissions.

The appendix on the Examination of Urine by Dr. Lawrence Wolff is a very fair presentation of the subject in a concise and convenient shape.

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BACTERIOLOGICAL TECHNOLOGY. By C. J. SALOMONSEN. Translated from the second Danish edition, by William Trelease. Pages 162. William Wood & Co., New York.

In presenting this book to the profession the author had two objects in view (preface): The publication of an outline adapted to bacteriological courses for physicians, and a guide for those who are obliged to take up the subject at home without the assistance of an instructor. This is therefore no elaborate treatise on bacteriology. However, the methods of bacteriological technique, such as sterilization, culture media, inoculation of animals, staining of bacteria, etc., are described with sufficient detail to make the work a very valuable manual. For sometime there has been a demand for a book of this sort for English readers, and we believe that this want is now supplied.

**THE YEAR-BOOK OF TREATMENT FOR 1891.** Lea Brothers & Co. Philadelphia. Pages 480. Price \$1.50.

The favorable reception which these Year-Books have received from the profession in the past has encouraged the publishers in the current issue to add considerably to the size of previous ones. The original purpose, namely, to supply a concise epitome of the chief articles of the preceding year, with a short criticism of the more important subjects, has not been altered. The list of contributors is sufficient guarantee. These represent every department of medical art. Diseases of the Heart and Circulation, by Mitchell Bruce; Diseases of the Nervous System, by James Ross; General Surgery, by Stanley Boyd; Diseases of Women, by Berry Hart; Diseases of the Genito-Urinary System, by Reginald Harrison; and so on with other names of equal merit.

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**MATERIA MEDICA, PHARMACY AND THERAPEUTICS.** BY SAMUEL O. L. POTTER, M. D., Professor of the Theory and Practice of Medicine in the Cooper Medical College of San Francisco, etc. Second edition. Philadelphia. P. Blankiston, Son & Co.

Perhaps the text-books in no department of medical science are more unsatisfactory than those of *Materia Medica*. In spite of the classical works of Wood and Ringer and Brunton, it is not too much to say that what the student and practitioner most need has not yet been written. And it was this fact which led Dr. Potter, about five years ago, to prepare the first edition of the above work for the advanced student and junior practitioner. The book is divided into three principal parts, *Materia Medica* proper, *Special Therapeutics of Disease*, and *Official and Extemporaneous Pharmacy*. The author adopts the alphabetical arrangement of drugs, which is not so good as the physiological method of Wood,

but better than the botanical arrangement of Brunton. The department of Special Therapeutics is complete and valuable.

We do not hesitate to give our cordial recommendation to this book, and we may congratulate Dr. Potter on the warm reception which has been recorded his work by the profession. We believe the general practitioner will find this to supply his needs more nearly than any other book on the subject with which we are acquainted.

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ESSENTIALS OF MINOR SURGERY, BANDAGING, AND VENEREAL DISEASES. By EDWARD MARTIN, M. D., Instructor in Operative Surgery, University of Pennsylvania, etc. Pp. 166. Illustrated. W. B. Saunders, Philadelphia.

The subjects usually embraced in "minor surgery" are discussed in this little volume as fully as the allotted space will permit. The modest little book presents in a neat and accessible shape a great deal of useful advice and suggestion not found in large works. Forty-six pages are devoted to chancroid, gonorrhœa and syphilis. In the diagnosis of gonorrhœa the author seems to us a little radical. This, he says, cannot be positively made in the absence of the gonococcus. In the discussion of syphilis we see nothing new.

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ESSENTIALS OF DISEASES OF CHILDREN. By W. M. POWELL, M. D., Physician to the Clinic for Diseases of Children in the University of Pennsylvania, etc. Pp. 222. W. B. Saunders, Philadelphia.

This little book is a fair presentation of this great subject, and is doubtless all that the author claims for it. The introduction consists of remarks on examination in general, fæcal evacuations, vomiting, the pulse and temperature.

Necessarily diseases of the alimentary canal and acute infectious diseases receive considerable attention. The different diseases are handled with special reference to symptoms, diagnosis and treatment. As far as it goes this "essential" fulfills its purpose.

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## TO CONTRIBUTORS.

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## Original Communications.

### OBSERVATIONS ON KOCH'S LYMPH.

By JOSEPH JONES, M. D., of NEW ORLEANS, LOUISIANA.

156 WASHINGTON AVENUE, CORNER OF CAMP STREET, )  
NEW ORLEANS, LOUISIANA, April 28th, 1891. (

*His Excellency, Benjamin Harrison, President of the United States of America, Washington, D. C.:*

SIR—I have the honor to acknowledge the following:

EXECUTIVE MANSION, WASHINGTON, January 19th, 1891.

*Professor Joseph Jones, Charity Hospital, New Orleans, La.:*

MY DEAR SIR—At the President's direction, I beg leave to send you by express one vial of Koch's lymph for such use as you may deem wise to make of it.



It was forwarded to the President by the American minister in Germany.

Very truly yours,

E. W. HALFORD,  
Private Secretary.

I beg leave, respectfully, to submit to your Excellency the following brief report on this vial of Koch's lymph :

The small vial of "Koch's Lymph," containing about five grammes (about seventy-six drops) of a dark brownish red liquid, accompanied by directions for its use, signed by Dr. A. Libbertz, of Berlin, Germany, was delivered to me in person, at my office, 36 University Place, by the express agent.

Holding that your Excellency designed this humane bequest, not for private ends, but for the benefit of suffering humanity, and the promotion of scientific inquiry, I placed a portion of "Koch's lymph," contained in the small vial, at the disposal of the medical and surgical staff of the Charity Hospital of Louisiana, as will be seen from the following correspondence:

OFFICIAL BUSINESS.

36 UNIVERSITY PLACE, NEW ORLEANS, LOUISIANA, }  
January 22d, 1891. }

*Professor A. B. Miles, M. D., Resident Surgeon Charity Hospital,  
New Orleans, La.:*

MY DEAR DOCTOR—On the 22d instant I received by express a small vial of "Koch's Lymph," together with the enclosed communication from the Private Secretary of his Excellency, President Harrison. \* \* \*

I respectfully tender to the Surgeon in charge of the Charity Hospital, and through him to the medical and surgical staff, a portion of the "lymph" for the treatment of the patients in the wards of the Charity Hospital, provided that I be furnished with accurate reports of each and every case thus treated.

Respectfully your obedient servant,

JOSEPH JONES, M. D.,  
Visiting Physician Charity Hospital.

CHARITY HOSPITAL, STATE OF LOUISIANA, }  
NEW ORLEANS, January 26th, 1891. }

*Prof. Joseph Jones, M. D., Visiting Physician Charity Hospital. :*

MY DEAR DOCTOR—I beg to acknowledge receipt of your favor of the 22d instant, tendering to the Surgeon in charge of the Charity Hospital, and through him to the medical and surgical staff, a portion of the lymph which you have received from President Harrison.

Accept my thanks for your courtesy in this matter.

I will inform the members of the medical and surgical staff of your kind offer, and refer to you those who desire to experiment with the lymph in their ward service. Very truly yours,

A. B. MILES,  
House Surgeon.

We extract the following from the official proceedings of the Board of Administrators of the Charity Hospital, April, 1891.

“Dr. Miles reported relative to ‘Koch’s lymph,’ in which he said the world was taking interest.

“Dr. Joseph Jones had received a vial, and tendered it to the hospital. He had placed a notice on the bulletin board, inviting others to use it in safe bounds, if they thought proper.

“No one had applied to use it. For himself, he did not care to use it yet, as he did not deem the lymph or its substance sufficiently understood.

“It may yet be used in the hospital, but it would be best to await further results from it.”

Assisted by my chiefs of clinic, Dr. Stanhope Jones and Dr. J. M. Elliott, I examined the cases in the wards, under my care in the Charity Hospital daily, up to the middle of March, with a view to the use of “Koch’s lymph,” in the diagnosis and treatment of phthisis pulmonalis and other forms of tubercular disease.

That this agent or drug was not used in the treatment of diseases under my care, in the wards of the Charity Hospital of New Orleans, was due to the following causes:

(a) No case presented itself which I deemed suited to the application of “Koch’s treatment” without danger to the welfare of the patients.

(b) No case presented itself of which the diagnosis was so obscure as to require the institution of a doubtful experiment.

(c) Without exception, the patients under my treatment and care in those wards of the Charity Hospital declined to submit to this mode of treatment.

(d) The extensive prevalence of *influenza* in a severe and often fatal form, and which attacked with especial violence those suffering with phthisis pulmonalis, rendered the injection of an irritating agent into the living human body hazardous.

In accordance with what I concede to be the humane and charitable intention of your Excellency, I have held the small "vial of Koch's lymph" sacred to scientific and charitable investigations.

I have received a number of applications from physicians and private individuals for the use of this "Koch's lymph," in private practice and in institutions other than the Charity Hospital of Louisiana, and I have uniformly refused such applications. Such applications appear to have been based upon a misapprehension of the intention of your Excellency, and upon ignorance of the therapeutic value and power of a quantity of liquid too small to supply more than one drop and a half to each one of the 52 wards of the Charity Hospital, with a daily average of 550 and an annual average of about 7,000 cases of all diseases.

#### OUTLINE OF RESULTS OF CHEMICAL AND MICROSCOPICAL EXAMINATION OF THE CONTENTS OF A VIAL OF KOCH'S LYMPH.

The objectives employed in the following observations ranged from  $\frac{1}{4}$  to  $\frac{1}{15}$  of an inch. Due precautions were taken to secure such results as were possible in the chemical and microscopical manipulation of the small amounts of material.

#### PROPERTIES OF KOCH'S LYMPH.

1. Reddish-brown liquid, with oily movement and consistency of thin glycerine.
2. Clear, with a few minute flocculi.
3. Musty odor like that of stale beef extract.
4. When burned emitted an odor like burning beef extract.
5. Reaction strongly alkaline.

6. When a drop of the undiluted liquid was placed in the eye of a living animal, it appeared to cause a disagreeable sensation, attended with closing the lids temporarily, but it induced no permanent irritation or inflammation. A repetition of this experiment caused no perceptible injury to the eye or animal.

7. No appreciable effects were induced by the lymph when administered internally, by the mouth, to living animals. The fluid in its innocuous effects, when applied to living mucous membranes, differed from the poisonous alkaloids, and from prussic acid and the cyanides.

8. Mingles rapidly and freely in all proportions with distilled water.

9. When injected in varying degrees of dilution with distilled water (50 per cent., 25 per cent., 10 per cent., 1 per cent., 0.1 per cent.) into the subcutaneous tissues of living animals, cats, rabbits and guinea pigs, only slight local irritation and no sloughing were induced at the points of injection. The injections were followed by fever of greater or less intensity and duration. The animals appeared to regain their normal condition in varying periods, from four to seven days, but were reserved for future observation. The liquid appeared to be far inferior in its immediate effects when injected subcutaneously, to prussic acid, strychnine and serpent poison; neither did it manifest effects identical with septic poison.

10. Uncoagulated by heat.

11. Uncoagulated by heat and nitric acid.

12. Uncoagulated by nitric acid.

13. Chemically pure, absolute alcohol threw down from the lymph a flocculent whitish deposit.

14. Nitrate of silver threw down a heavy white deposit, showing the presence of chlorides in considerable quantity.

15. Soluble baryta salts gave slight precipitates.

16. Stannous salts gave no evidence of the presence of the salts of gold.

17. Microscopical examination of the undiluted "Koch's lymph," with objectives ranging from 1-5 to 1-15 of an inch, revealed the presence of minute ovoid and rod shaped bodies,

resembling the spores and bacillus of the bacillus tuberculosis as originally described by the eminent microscopist, Robert Koch. These micro-organisms in their size structure and behavior, with staining fluids, corresponded with the bacillus tuberculosis.

18. When the "lymph" was diluted with boiled, distilled water and preserved in chemically clean test tubes, the mouths of which were carefully guarded by antiseptic cotton wool, the fluid became turbid. Microscopical examinations revealed the fact, that the turbidity was due to the multiplication of micro-organisms presenting physical and chemical properties similar to those of the bacillus tuberculosis.

19. The addition of a drop of the "lymph" to "Pasteur's sterilized liquid" was followed by the development of the spores and slender, rod-shaped micro-organisms, resembling the bacillus tuberculosis.

20. The spores and bacilli of "Koch's lymph" were cultivated, and with the necessary precautions to exclude all external germs from the atmosphere and internal objects, upon various substances, as serum of blood, boiled potato, white of egg and crystallizable sugar.

21. In cultivations in fresh blood the reaction was strongly alkaline, in those of the potato, white of egg and sugar they were acid.

22. When a small quantity of the lymph was added to a carefully sterilized solution of crystallizable sugar, the clear solution became turbid and emitted a sweetish odor, similar to that which I have often observed to be exhaled by patients suffering from phthisis pulmonalis in the advanced stage.

#### CONCLUSIONS.

(a) The active principles of "Koch's lymph" appear to reside in a colloid nitrogenized compound, coagulable by absolute alcohol, and in living germs, micro-organisms, spores and bacilli, similar to those of the bacillus tuberculosis, and capable of multiplication within and without the living organism.

(b) The potent effects of Koch's lymph, when introduced into the blood of healthy and diseased human beings, may be

referred in part at least to the rapid multiplication and action of micro-organisms similar to, if not identical with, the bacillus tuberculosis.

(e) The results of the chemical and microscopical examination of the contents of this "vial of Koch's lymph" have led me to exclude this liquid from the list of remedial agents.

I beg to be permitted to say that in the effort to discharge what appeared to be my duty, I have endeavored to serve the art and not the trade of medicine, believing that honorable, legitimate medicine has no secrets to conceal, and holds no remedy which is not the common heritage of the glorious brotherhood of the noble republic of science.

With great respect and with many thanks for the generous consideration of your Excellency, I have the honor to remain

Your obedient servant,

JOSEPH JONES, M. D.,

Professor of Chemistry and Clinical Medicine, Medical Department Tulane University of Louisiana, Visiting Physician Charity Hospital, New Orleans.

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## SUGGESTIONS ABOUT ABDOMINAL AND PELVIC SURGERY.\*

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By WM. H. WATHEN, M. D., OF LOUISVILLE,

Professor of Abdominal Surgery and Gynecology in the Kentucky School of Medicine, Gynecologist to the Louisville City Hospital, etc.

The recent contributions upon abdominal and pelvic surgery are probably more numerous and practical than upon any other department of general or special surgery; still there is a variety of opinion as to the best methods of treating pathological conditions within the peritoneum, or as to the immediate or permanent results of the many procedures that have been practiced.

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\*Read before the Obstetrical and Gynecological Section of the American Medical Association, May 8, 1891.

This is especially true of pelvic surgery, where we find in the practice of the most experienced and successful operators accidents during the operation, and complications following it, for the prevention of which there is no united opinion as to the correct technique to adopt; nor is it always possible to explain why troublesome complications occur in one case and do not occur in another apparently similar case. Careful observation and experience may finally teach us much wisdom in these matters, and I will ask your kind indulgence while I briefly allude to a few things that may be of value, if carefully discussed by the members.

There is too much laparotomy done, and too many men are doing it; men who know too little about the diagnosis and pathology of abdominal or pelvic diseases, or about the best technique in operating, and have few facilities for doing such work. Continuously good laparotomy work cannot be done except by men who largely devote themselves to this department of special surgery, and with such men some cases are operated on where the indications do not justify it. The appendages are sometimes removed for vague nervous troubles, where there is no disease of the ovaries or tubes, or peritoneal adhesions. Such cases are made worse and are mutilated in a way that cannot be corrected.

The pendulum has swung too far, but many of our best operators are earnestly urging upon the medical profession that the operation is not indicated except in cases where there is well defined disease that has resisted, or will resist, other more conservative means.

As the experience of an honest surgeon widens, he operates relatively, less frequently and he can recall cases that he does not believe should have been operated on. An honest, intelligent, and careful man may, when young in observation and practice, make mistakes in the selection of suitable cases for laparotomy, but this is less frequent than it was a few years ago. It is criminal to do dangerous or capital operations while ignorant of the best methods for doing such work, or for the purpose of adding a little cheap glory to our reputation; or to report cases that apparently recover from the immediate effects of the operation

as permanently relieved before the final results can be appreciated. Such men usually have many bad results or deaths that they do not report so promptly, and the profession, or the people, seldom hear much about them.

I have reported but a small minority of my successful cases, but have promptly reported my bad results or deaths because by a careful study of such cases we finally do better work, by learning how to avoid or prevent complications or accidents that may cause the death of our patient. Reported recoveries in simple cases of laparotomy do not always indicate superior or unusual skill in the operator; such reports are of little value to the medical profession and may indirectly result in the death of many women by influencing ignorant men, with no facilities for such work, to attempt it because of its apparent simplicity.

What I may say relative to the technique, etc., of laparotomy refers to cases where the conditions are manifestly such as to positively indicate the necessity for operation. In preparing for an operation, the physical and mental condition, and the hygienic and sanitary surroundings of every patient should be made as perfect as possible under existing circumstances; and unless absolute surgical cleanliness is observed in everything that may come in contact with the wound or peritoneum, septic infection may follow.

Some operators, who talk a good deal about antiseptics, do not know how to be surgically clean, because they have not learned to appreciate the value of cleanliness in every detail before and during the operation. The infection often comes to the patient by the neglect of little things, without the strict observance of which no man can be a successful abdominal surgeon. The danger from atmospheric infection is practically *nil*, as has been shown by Kummel and others, and by the continuously good results in operations done in large amphitheatres before several hundred students. It may be possible for septic matter to reach the peritoneum through the intestinal walls, but this has not been proven. A spray of antiseptic solutions is not necessary, and if strong enough to kill pathogenic germs supposed to be floating



in the atmosphere, it is positively poisonous if used during an abdominal section.

Some men, who use the spray Don Quixote-like, while pursuing an imaginary foe, allow the deadly enemy to enter through numerous neglected channels—the hands, sponges, sutures, instruments, etc. Every operator should of course observe the broad principles that make the foundation of all good surgery, but if he neglects the details he will be disappointed in the results. Asepsis is more easily accomplished in well regulated private or public hospitals or infirmaries. In private houses septic matter may be more readily introduced unless the operator, or an experienced nurse, rigorously superintends everything before and during the operation.

That we may better appreciate the practical significance of my position as to what constitutes asepsis in laparotomy, I will give some of the methods before and during an operation. I prefer not to operate in a room where the patient is afterward to stay, and when I am compelled to do so, if delay is admissible, I have the room thoroughly cleansed and ventilated for twenty-four hours before the operation, but use no spray or other means of disinfection. When it can be done I operate in a room at St. Joseph's Infirmary, specially prepared for laparotomy work and so arranged that everything in or about the apartment can be kept aseptic with but little care. The operating tables for the surgeon and nurses have plate glass covers, and the trays for instruments and pans for sponges and dressings are white porcelain-lined.

Everything is carefully cleansed before each operation, and the operator and his chief assistant take a bath and put on clean linen, and white aprons reaching from the neck to below the knees and extending entirely around the body, so as to prevent the hands coming in contact with anything unclean. The towels are carefully washed and boiled and are used for no other purpose. Soft and well shaped sponges, free of sand or grit, are selected, and after being carefully washed are made aseptic after the method of Greig Smith. Eight ounces of bisulphide of soda and four ounces of oxalic acid are dis-

solved in a gallon of water, in which twelve to twenty sponges are immediately immersed and kept for ten minutes; they are then washed by frequent changes of water for one hour so as to get out all the sulphurous acid and sulphur. This is quite a labor, but it insures perfect freedom of septic matter. They are then wrung out of the water and put into a clean cotton or linen bag so as to keep out the dust while drying. When dry they are put in large ground glass stoppered bottles or jars, and may be kept indefinitely in a pure condition.

Sponges once used may again be made aseptic by the same process, but I prefer not using them a second time if they have been soiled in septic matter. If a sponge comes in contact with anything that may be unclean, it is not used until again prepared. Chinese hard-twist silk of three sizes is used. It is purchased in unbroken packages and wound loosely on separate glass spools. These are put into glass test tubes which are stoppered with a piece of absorbent cotton and then sterilized. They are kept in the sterilizer for an hour, for three consecutive days. The silk is now so free of bacteria that a culture could not be made from it, and if the cotton is not removed it will stay in this condition. Each tube contains enough silk for a laparotomy. The silk and needles are kept during the operation in sterilized water at a temperature of 212 degrees. This may not be necessary, but if the cotton has been partially displaced from the tube, it would be a wise precaution.

In the same boiling water I keep the small glass drainage and the large irrigation tubes. As our hydrant water is generally muddy, I use sterilized water, and always have it boiled in vessels kept for this special purpose. The instruments are washed with sapolio or some strong soap, and boiling water is poured over them, when I begin the operation. The hairs of the brush are pushed through the eyes of the needles and the holes in the instruments so as to get away all poisonous matter. It is well to have instruments, towels, dressings, etc., sterilized for an hour before using them, but they should be thoroughly washed before sterilization.

The patient is given one or more hot baths by a well-trained

nurse; the vagina and rectum are washed with copious injections of hot water, and the pubes is shaved. Before making the abdominal incision the abdomen is again washed with soap and brush, and wiped off with sulphuric ether. Dry towels, covered by towels wrung out of boiling water are placed over the abdomen so as to prevent anything possibly unclean coming in contact with the hands or any of the appliances used. The nails are closely cut and the hands thoroughly washed with brush and soap before the operation.

The nurses in charge of the sponges, needles and sutures are as aseptic as the operator. I use no antiseptic solutions, but use for sponges, instruments and hands, boiled sterilized water kept as hot as can be borne. If everything is aseptic we don't need antiseptics; and they may cause general or local trouble. I will refer to but a few points in the technique of the operation. Adhesions are carefully separated close to the tumor or structure to be removed, or the uterus, to prevent hemorrhage or wounding the intestines or bladder. Adherent intestines should be separated if possible, otherwise the operation is incomplete, and the patient will not probably be permanently, if at all, relieved.

The patients sometimes suffer more after the operation than before it, because of the extensive adhesions induced by uncleanness, antiseptics, or traumatism committed by a careless operator. I believe adhesions will be fewer if antiseptics are absolutely excluded from the operating room, and are not even used for the instruments or the hands. This may seem heterodoxical to many, but I have arrived at this conclusion after experience and careful observation. If the instruments and the hands are clean we need no antiseptics, and if they are unclean the solutions will not cleanse them, or prevent infection, but may so irritate the peritoneum as to cause few or many adhesions. It will require more experience to decide how much damage is done in this way. Blood, pus and all foreign matter should be removed, and great care should be practiced to prevent rupturing a pus sac or cavity in an operation for their removal.

When any foreign matter except blood has gotten into the cavity it should be thoroughly irrigated with hot sterilized water.

This is not only the best way to cleanse the peritoneum, but it is also an excellent means of preventing or treating shock. This may be done by attaching one end of a three-foot piece of gum hose to a glass tube, and the other end to an iron-granite funnel, into which water is copiously poured and forced by hydraulic pressure through all parts of the abdomen and pelvis.

The drainage tube is sometimes invaluable, but if improperly used it is capable of doing much mischief. There are many cases in which it is indicated; there are many in which it is not. It should be used if we close the abdomen before hemorrhage has ceased, or if foreign matter, that is possibly septic, has gotten into the abdomen. It should be attentively cared for and frequently emptied with a long nozzle syringe by a well trained nurse. It should be very small and light, with open end, and numerous fine openings on the sides. It should be carefully placed and long enough to enter to the deepest part of the pelvis.

After the dressings are applied around the tube, a twelve inch square piece of gum dam, with a small hole cut in the center, should be closely fitted around the neck so as to keep the dressings clean. If a piece of absorbent cotton is kept over the mouth of the tube and held in position by folding over the gum cloth, it will absorb discharges and remove the danger of sepsis from the introduction of pathogenic germs. It should be removed when soiled and a new piece used.

Some of our best known laparotomists use too large drainage tubes and do not protect the dressings and the wound by the gum dam. A small tube will usually drain as well as a large one, and it does not subject the patient to so many dangers.

While it has been shown by Grawitz that the peritoneum may render harmless, and dispose of pus or pathogenic germs, it would be reckless to expect it to do so when we may supplant the efforts of nature by the use of a drainage tube through which irrigations may be used if needed. The long nozzle syringe, or a syringe with a small gum tubing attached, affords the best means of emptying the tube, and this can be done aseptically. The practice of trying to drain the peritoneal cavity by introducing strips of gauze or wick into the tube to its bottom,

or allowing shreds to enter the cavity as practiced by German laparotomists, is bad surgery, and may be a means of introducing septic matter. While aseptic gauze may usually drain efficiently, it sometimes prevents drainage and causes the blood to coagulate in the tube. This is especially true where capillary drainage is attempted by the use of the wick. I have never seen coagulation where the syringe was used. Probably the most correct exposition of the methods of drainage in Germany will be found in the paper, "Drainage in Laparotomy," by Saenger, of Leipzig, at the recent meeting of the Tenth International Medical Congress at Berlin. No mention is made of protecting the dressings from the discharges by the use of gum dam, or of removing the secretions with the syringe.

Vaginal drainage, with possibly a few exceptions, should never be attempted, though Dr. August Martin, of Berlin, and other German operators frequently practice it. It can accomplish nothing more than supra-pubic drainage and subjects the patient to greater dangers from sepsis. The tube should be removed as soon as the conditions will admit, and when bleeding has practically ceased, and there is only a small quantity of clear inodorous liquid removed, it is no longer needed. If the tube has to be retained more than forty-eight hours, it should be rotated a little twice daily so as to facilitate drainage by preventing obstruction in the small openings.

The dressings need not be disturbed to remove the tube, and in a few weeks the place where it was introduced can scarcely be detected; and ventral hernia will not occur at this point more easily than at any other part of the incision. Hernia in any case will seldom occur if we are careful to unite the ends of the abdominal fascia. This may be done by the deep suture if the fascia is drawn out and the needle correctly introduced, but the separate suturing of the fascia is more reliable.

Recognizing the fact that in laparotomy work death is too often caused by septic infection, and that this can nearly always be prevented, I am deeply in earnest in my desire to aid in impressing upon the medical profession what I conceive to be the

best means of preventing the introduction of septic matter. As death occasionally follows prolonged anesthesia in organic diseases of the heart, lungs or kidneys, we should carefully examine these organs before we decide to operate.

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## WHEN SHOULD WE INTERFERE IN THREATENED PUERPERAL CONVULSIONS ? \*

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By EVERARD H. RICHARDSON, M. D., ATLANTA, GA.

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The proper treatment of threatened cases of convulsions occurring during pregnancy is a subject of supreme importance both to the general practitioner of medicine and to the *accoucheur*. No subject in the domain of medicine is of greater interest to the human family than this grave condition complicating pregnancy, and generally supposed to arise from albuminuria and uræmic poisoning. (All other forms of convulsions are excluded from consideration in this article.) It is not the purpose of the writer to enter into the etiology or pathology of puerperal eclampsia. Its treatment alone will concern us ; and in its consideration we shall speak from the standpoint of the clinician rather than the theorist, promising that facts, in contradistinction to theories, shall dominate in the exposition of the subject. If, in this thesis attempting to set forth the rational and correct treatment for the management of the class of cases under survey, the writer should appear arbitrary or dogmatic, my apology is that I have very positive and absolute convictions on the subject ; and I contend that upon a subject of such vast concern to our race, where the issues of life and death are to be decided so quickly, every one called upon to confront and solve a condition so grave should have crystallized convictions and matured opinions, that he may act, and act promptly, in interest of his patient.

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For purposes of illustration the following hypothetical case is presented, which I trust, will be found true to nature : The patient tells us that she has suffered for some days with a severe headache, giddiness, confusion of ideas, restlessness, very nervous and easily fretted. She says that her headache is insufferable, that she has optical illusions, unnatural sounds in ears, and at times has spells of blindness with difficult articulation. Hypochondria and gloomy forebodings of evil are marked. The above are the more prominent subjective symptoms usually present. Coupled with them the objective phenomena observed are, a flushed face, injected conjunctiva, an unnatural stare from eyes; increased heat of skin may or may not be present ; nausea and vomiting, a variable degree of œdema of lower and upper extremities, extending in some instances to the face, may exist. With this group of symptoms albumen is generally found present in the urine, and the secretion of urine is scant. Under the microscope renal epithelium, casts, blood corpuscles and fibrin cylinders are also observed. The patient presenting these symptoms is usually in the latter half of pregnancy. What then is the duty of the physician when called upon to treat a patient thus suffering, and presenting these symptoms ? Is he justified in wasting precious time by going through the catalogue of remedies supposed to relieve the cause of the symptoms present and prevent the advent of convulsions ? Every moment lost in an expectant or tentative treatment enhances the chances for the supervention of convulsions, which subject the physician and friends to confront the most terrible ordeal and witness the saddest spectacle incident to human life—a mother writhing in convulsions. In the vast majority of such cases *presenting these symptoms* medical treatment is impotent and futile in preventing an outbreak of convulsions. These symptoms show unmistakably profound uræmic poisoning of the nerve centres, and an explosion in the form of terrific convulsions is liable to occur at any moment. The life of the patient is seriously imperilled ; the malady and its attendant results so seriously threatened is grave, terrific, and like an avalanche in character. I am confident that here an expectant and vacillating policy on the part of the phy-

sician will inevitably result in the loss of very many valuable lives that might otherwise be saved, and should not for a moment be tolerated by an enlightened profession. I am firm in the conclusion that it is now a very grave responsibility for the attending physician, the guardian of a human life, to fold his hands and content himself by instituting an expectant plan of treatment, hoping with any degree of confidence to avert by any therapeutic agencies now known to the profession, an onslaught of eclampsia. Treatment in all such cases, to be efficient or promising satisfactory results, must be not only active and prompt, but radical and heroic. The few instances in the past where I have voluntarily placed myself in this attitude, I look back upon with feelings akin to the most exquisite martyrdom and excruciating torture. The uplifted and falling lash that I so painfully see through retrospective lens admonishes me to declare, with all the earnestness and emphasis which the gravity of the situation demands, that the only adequate treatment, the only one promising satisfactory results, must be to thoroughly empty the uterus by the institution of means necessary to produce artificial premature delivery.

The underlying cause of the above symptoms, I think, are due to uræmic poisoning dependent upon acute Bright's disease of pregnancy ; and of this malady the late Carl Braun, of Vienna, says "complete cure is rarely obtained during pregnancy, because the cause of it, the obstruction of the venous circulating in the kidneys, is not easy of removal." But be this as it may, without equivocation or reference to authority on the subject, I wish to give my own views as to the importance in all such cases, *with the symptoms* just narrated, of at once instituting means to terminate the gestation as speedily as possible.

The best means of accomplishing this is by the introduction of an elastic bougie or catheter, under aseptic precautions, into the uterus, supplemented at the proper time by the use of Barnes' uterine dilators. However, *pari passu* with our efforts to accomplish delivery, it is important to get free catharsis from the bowels of patient by elaterinum, calomel, croton oil or hydragogue



cathartics, as the emergency of the case may demand. Other measures of treatment are important.

If the symptoms are very urgent, the patient of full habit and nothing to contraindicate it, one general venesection is to be recommended; this relieves promptly both vascular tension of the brain and kidneys and the toxic influence of the *materies morbi* of the blood, and twenty to thirty grains chloral hydrate is advisable. The patient's room is to be darkened, and she must either be kept under the influence of the chloral, or she must be given chloroform by inhalation during the pains. It is customary to recommend the administration of bromide of potassium in such cases. But I desire to say that there is but one form of convulsions benefited in the least by this agent, and that is epilepsy. It is of undoubted service in the treatment of epilepsy, but I know of no other disease in which its administration is of the slightest advantage. The chloral hydrate in decided doses is not second in importance to even chloroform; and I strongly recommend the importance of its administration—fifteen grains of this remedy by the mouth every twenty or thirty minutes, or thirty to forty grains per rectum every few hours, until the system is brought under its influence, is greatly to be desired in preventing and controlling convulsions. After the uterus has been well dilated, and if the head does not make sufficient progress, there is no objection to the use of forceps. The important desideratum in the management of all such cases is to deliver as speedily as possible, compatible with safety, using the usual auxiliary means to expedite delivery.

The testimony of Prof. Braun is that "the fits completely cease after evacuation of the uterus in 37 per cent. of cases, become weaker in 31 per cent., and in 32 per cent. only continue of the same severity."

According to my own observation and experience, where the uterus has been emptied, the convulsions have never recurred, except in a very mild form, and I have never known a woman to die from convulsions after delivery had been effected. For purposes of further illustration I will mention the case of Mrs. A.

Was called in consultation with Dr. B. F. Wright, of Polk

county. Mrs. A. was in labor at about eighth month of pregnancy; had had a convulsion, but was quiet and asleep when I arrived. Head was well advanced, and I suggested the propriety of using forceps, and delivering as early as possible. Dr. W. insisted on waiting, as he thought child would soon be born. I yielded to him and waited, but only to see the development of hard convulsions in a short time. At once I bled the patient to the extent of twelve to fifteen ounces, and chloroform by inhalation was then administered; while she was still having convulsions I introduced forceps and soon delivered her, to my astonishment, of a living child. Before she came from under the anæsthetic, by *Crede's* method the placenta was delivered. She was washed and placed in bed. As soon as she came from under the influence of chloroform the convulsions returned. Chloroform by inhalation was again resumed. We stood over her till 12 o'clock at night, keeping her under its influence. At this hour we retired, leaving two nurses with instructions that whenever the patient was not asleep and *moved* to administer more chloroform by inhalation. By morning we had the gratification of finding the mother rational and free from danger. Both she and child did well.

Do you ask me to be more explicit and say how soon do I recommend the induction of premature labor in the albuminuria of pregnancy? To this I reply that in all cases of pregnancy, whenever albumen in the urine is persistently found in large quantities, with or without the presence of any variety of casts, and not yielding promptly to treatment, *whenever decided symptoms* of profound uræmia appear and *continue unabated*, then I *unqualifiedly* recommend and advise as the safest course to be pursued in the interest of the mother the induction of premature labor. In the face of the facts, the argument that under medical treatment cases of eclampsia may occur and terminate in safe delivery at full term counts for nought when it is remembered that these are exceptional cases and not the rule. In more than fifty per cent. of the cases the lives of the children are sacrificed as a result of the circulation of urea in the maternal blood, and with the restrictions here mentioned the question of preserving

the life of the foetus should not be taken into consideration. But the question of superlative importance and paramount to that of all others is, by what method of treatment can we save the greatest number of lives of mothers when imperilled by the malady so much dreaded by all obstetricians.

My views on the subject have been given as the result of personal experience and observation, and without reference to obtaining views of authorities as disclosed in contemporary medical literature. Satisfied that whatever may at present be the *dictum* of authority on this subject, time, the great crucible of all questions, will demonstrate to the candid seeker of truth the correctness of the views herein enunciated. But please do not misapprehend me, and for a moment fancy that I advocate the interruption of gestation for the acute albuminuria of pregnancy, for I am aware that perhaps in the majority of the mild cases of albuminuria occurring during pregnancy they may be safely carried to the end of utero-gestation. For the albuminuria of such cases remedies must be directed to the relief of the kidney insufficiency, and the list of therapeutic agents that have been used with varying degrees of success is a long one. If casts are present in the urine the patient should be confined to bed, and placed upon a milk diet. Benzoic acid, lemon juice, tartaric acid, digitalis, acetate of potassium, coupled with diaphoretics and aperients have all been used and sanctioned by high authority. Dr. H. V. M. Miller of this city has for a number of years treated the albuminuria accompanying pregnancy by the internal use of chloroform, giving from ten to twenty drops every six or eight hours according to the urgency of the symptoms. His own testimony and that of a large number of his followers in this section is unbroken in praise of the efficacy of this method of treatment, the disappearance of the albumen and casts from the urine during treatment attesting the virtue of the treatment. Dr. A. W. Griggs, of West Point, Ga., has also long been an ardent advocate of the chloroform treatment (internally administered) for the acute albuminuria of pregnancy. In chronic Bright's disease of women the subjects should never be permitted to become pregnant. Where pregnancy has occurred in

such subjects abortion or premature labor should at once be produced without hesitancy.

But in the cases of albuminuria that have progressed until the nerve centres have become deeply poisoned from the circulation of urea or some poisonous substance in the blood, as shown by prominent head symptoms, then it is that the expectant treatment amounts to playing with the thunderbolt—dallying with human life.

Corroborative of the position taken by the writer in this article, Dr. B. C. Hirst very recently said before the Philadelphia Obstetrical Society that “if mistakes must be made in these cases, and they are inevitable in a situation involved in so much obscurity and doubt as to the outcome, I would prefer occasionally to sacrifice the fœtus unnecessarily rather than occasionally to lose both mother and child by a temporizing policy.” And in advocacy of interference he further says, “in any case in which I was in serious doubt as to the course to pursue in the future, I would always decide in favor of terminating pregnancy.”

Dr. Edward L. Duer, in discussing the propriety of interference, said, “Where there is an alarming amount of albumen—say about twelve per cent.—examination of the urine should be made every two or three hours, and if the patient fails to respond to the treatment, especially if tube casts be present, I think we should risk the loss of the child rather than jeopardize the life of the child and mother.

#### ECLAMPSIA.

Upon the subject of the treatment of puerperal convulsions, when they appear there remains but little to be said. In the very beginning of treatment, unless contraindicated on account of great feebleness of the patient, phlebotomy, promptly resorted to, is very greatly to be desired.

Relieve the blood tension of brain, lungs and kidneys, thereby preventing apoplexy of brain and pulmonary œdema, and aiding at the same time the elimination of a certain amount of the *materies morbi* of the blood by the abstraction of from twelve to twenty-five ounces of blood. Next in importance is the administration of hydrate of chloral in very decided doses. Of this

agent give thirty grains by the mouth or sixty grains by the rectum, and repeat whenever the patient shows evidence of coming from under its influence.

Until the chloral has been absorbed, when there is a premonition of the advent of convulsions, chloroform, by inhalation, may be given. It is also important to obtain free catharsis by the action of croton oil, elaterium or calomel. Free diaphoresis by the hot wet pack, hot water bags, hot bottles, etc., is desirable. *Veratrum viride* I have used hypodermically with excellent results, but its use requires caution, and it is impossible or injudicious to use every good remedy on the same case. After the use of the agents above mentioned I have generally been able to dispense with *veratrum* in the treatment of puerperal eclampsia. *Pilocarpia* I allude to only to condemn its use in this class of cases. The use of morphia in the treatment of the eclampsia of pregnancy has been extolled and condemned by authorities of equal merit, and individual experience must decide its value. Rationally I do not think it indicated, and I am sure that I have never used it for the cases under consideration with the slightest benefit to my patients. It is also of supreme importance now to aid nature in her efforts to effect delivery of the child, either by digital dilatation of the uterus or with Barnes, or other dilators. Dilatation of the uterine canal having been accomplished, delivery may be completed by version or the forceps as the practitioner may elect. If during this procedure the mother has been assiduously kept under the combined influence of chloral and chloroform the heroic measures advised have very materially enhanced her chances of recovery.

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### PERITYPHLITIS.

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By JOSEPH McEVOY, M. D., ATLANTA, GA.

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This disease, "although not at all uncommon," is frequently overlooked or misunderstood, notwithstanding the fact that a

great deal has been said in our current medical literature about the affection and its proper treatment. What is known of the disease has not yet been embodied in our standard surgical works.

Since the plan of treating perityphlitic abscess by early incision was first adopted, the procedure has received considerable attention from American surgeons, and been fully endorsed by those who have published the results of their experience.

Further discussion of the subject is desirable in order that the disease may be readily recognized and submitted to proper treatment, and that we may be able to distinguish between those cases which tend to spontaneous recovery which are likely to terminate favorably without the aid of the knife, and those which necessarily call for surgical interference.

We therefore hope for a further discussion in order that we may gain additional information derived from the personal experience of some of our colleagues in regard to the pathology and treatment.

Various causes of the inflammatory condition under consideration have been assigned by systemic writers. The symptoms in nearly all cases point to a plastic inflammation of the connective tissue lying close to the cæcum. As the proximate cause of induration, lesion of the vermiform appendix is now understood as the immediate cause, the abscess resulting being primarily intraperitoneal.

Appendicitis is sometimes due to impaction of fæces in the cæcum—the presence of a foreign body in the organ. Idiopathic ulcer of the wall may lead to peritonitis and perforation, or the blood supply may be cut off from the organ by pressure of the surrounding viscera, thereby producing gangrene. The invariable occurrence of the disease on the right side is to be explained by reference to the cæcum and its appendix.

Perityphlitis does not always terminate in the formation of an abscess, as was once thought by some; the disease often disappears by resolution, without any signs of pus.

The diagnosis, as a rule, is attended with considerable difficulty; the pain may be entirely absent until perforation has occurred.

It is usually present, however, and is very acute; is most marked in the region of the cæcum. This comes on suddenly; the pulse is accelerated, and the temperature is considerably raised; an indurated swelling may be detected either by palpation in the right iliac fossa or by digital exploration of the rectum. When found in the rectum it is a firm, elastic mass, tender to the touch, and situated near the region of the caput coli. When seen externally, it seems to be deep-seated, and is usually located on a line extending from the right superior iliac spine to the umbilicus and about two inches from the iliac spine.

The onset of the disease is usually severe, being characterized by nausea and vomiting. Sometimes the pain is diffused, but after the lapse of two or three days becomes localized; the temperature varies from 100° to 105° F.

Induration comes on usually within forty-eight hours after the commencement of the attack, and generally subsides soon after the abatement of the other symptoms when recovery takes place by resolution. So far as the early symptoms are concerned, it is impossible to say whether the case will end in resolution, or whether it will go on to suppuration.

Resolution rarely ever occurs before the eighth or ninth day; when it does occur it is usually accompanied by a reduction of the temperature and a perceptible diminution of the pain, distention and abdominal tenderness.

Sometimes the tumor subsides rapidly, at other times months elapse before it entirely disappears. If, however, the case should go on to suppuration, the symptoms, which have already been described, will increase in severity, together with rigor, sweating, tympanitis and an increased extent combined with a diminishing firmness of the tumor. These are the chief points which indicate the existence of pus; they usually appear about the end of the second week, and can be discriminated from those following resolution, inasmuch as they are more intense in character, the patient instead of getting better is continually growing worse; whereas when resolution has taken place, they are milder and the latter course of the disease is comparatively more favorable.

The treatment of perityphlitis in the commencement of the attack, should consist mainly of local depletion. Opium should be given in doses sufficient to allay the pain, but quantities sufficient to induce narcotism should never be given. Purging in the early part of the disease, as experience has taught, can do no harm, but acts beneficially by removing any accumulation of *fæces* which may be impacted in the intestines, which, if allowed to remain, only increases the suffering of the patient and is liable to aggravate the existing inflammation; it also aids in the diagnosis by excluding *fæcal* impaction in the *cæcum*, which might be the possible cause of the symptoms. We are told by some that here, as in peritonitis, purging should be withheld, but as the analogy between the two diseases is not so very close, and for the reasons above stated, I am of the opinion that purgation in the commencement of the affection is very essential, but should not be repeated, as a subsequent accumulation can be avoided by a careful restriction of the diet and by selection of light and nutritious articles of food, in connection with the treatment already briefly outlined. If absorption of the inflammatory products seem to be unduly retarded, blisters may be applied or mercurial applications may be resorted to.

If, however, the case should go on to suppuration and pus is evident, operative interference must not be postponed; an incision should be made, "running parallel with Poupart's ligament, about three inches in length directly over the tumor, cutting through the skin and subcutaneous fat; the deeper layers should then be divided until the *fascia transversalis* is reached; the wound should grow narrower as it increases in depth, in order that a subsequent hernial protrusion might be avoided. If, after having reached the *fascia transversalis* or abscess, fluctuation is evident, the abscess may be opened immediately, but if there is any doubt as to the locality of the abscess the *fascia* may be penetrated in various directions by means of a hypodermic needle, 'as Parker has recommended,' until the seat of the abscess is discovered, which should then be evacuated and drained. If the appendix be found diseased, it must be tied off by means of a ligature of silk close to the *cæcum*. A most perfect cleansing of the parts should



be looked after, especially if perforation has occurred, taking care to use all antiseptic precautions. The wound should not be sewn up, but should be packed with iodiformized gauze, which should be removed after firm adhesions have been established."

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## A PLEA FOR CONSERVATIVE MINOR GYNECOLOGY.

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BY R. R. KIME, M. D., ATLANTA, GA.

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Shall the uterus be curetted? Is the curette the direct cause of pelvic complications requiring abdominal section, and shall its use be abandoned? Are questions that confront us for consideration when some of our eminent gynecologists are attributing many abdominal sections to minor gynecological work, classing as potent factors for evil the curette in the same category as the uterine sound. To quote from Dr. Joseph Price on the use of the sound, "If used at all, it should be in the hands of those with whom its application, by reason of their skill, will be exceptional, not usual, and the rule should be, that in the hands of the non-expert it should be forbidden, . . . . Along with the sound may be placed the curette in the same category."

This certainly is an extreme view of the use of the curette, and while an improper, injudicious use of the curette may often cause pelvic difficulties requiring abdominal section, it certainly is often a very potent factor, properly used, in preventing those conditions requiring abdominal section. Because serious results follow the injudicious use of the curette, it should not constitute an edict to consign its use to oblivion any more than abdominal section should be consigned to oblivion because of its abuse and the disastrous results following some operations.

If it can be established that the curette has accomplished good,

relieved suffering woman, prevented more serious complications, then its abuse should be condemned and not its use.

In considering this subject we will necessarily have to enter to some extent the domain of obstetrics, because the complications incident to labor, abortion and miscarriage often bear a direct relation to gynecic surgery. It is not the object of this article to discuss antiseptic or aseptic obstetrics, but to deal, so far as the application of the curette is concerned, with some of the complications following labor, abortion and miscarriage. It is the teaching of surgery where we have foreign, diseased, broken-down tissues to scoop out, scrape out, remove, cleanse cavity, drain and dress antiseptically.

It would certainly be rational to apply same principles to the uterus where it contains foreign substances and diseased tissues, broken-down decomposing substances, or any structures keeping up continuous waste, sapping the vital powers of patient.

In septic infection or putrid intoxication, where uterus contains decomposing germ producing material, constantly being absorbed, menacing the life of the patient, wash out cavity of uterus, disinfect it — curette — again wash out, disinfect, drain and dress aseptically. If such procedures are instituted while the foe is yet confined to the uterus, before system is seriously affected by absorption or serious lesions have developed in other pelvic organs, I can well understand how abdominal section can be prevented rather than caused. By curetting thus performed, at the proper time, I think it is possible often to prevent subinvolution, pelvic peritonitis (pelvic cellulitis?), salpingitis, ovaritis and pyosalpinx, etc., thereby lessening the income of the abdominal surgeon.

In abortion and miscarriage there is certainly a wide range of usefulness for the curette. In those cases where nature fails to perform her work properly, the foetal structures passing off leaving maternal structures in uterine cavity to produce hemorrhage, decompose, causing more serious lesions when the condition of the uterus is such as to prevent the efficient removal of its contents by finger or hand, then I would say curette.

During the third month of pregnancy, when the ovular decidua

is rapidly atrophying, while the decidua serotina or placental decidua is as rapidly developing into the maternal portion of placenta, we are so likely to have those cases where the foetal structures pass off, leaving the newly formed maternal structures behind, causing hemorrhage that saps the vital powers of the patient, rendering her more susceptible to the deleterious influences occasioned by the decomposition of the retained structures. Allowing such a condition of affairs to continue is often the cause of many of the diseases the gynecologist is called to treat and the abdominal surgeon to relieve.

By the judicious use of the curette in these cases many complications can be averted, life saved and the use of the knife prevented.

To illustrate more clearly I report :

Case I.—Mrs. S——, multipara, missed two flows. Complaints of pains in bowels and pelvic region, nausea, headache, coated tongue, weak, debilitated.

Prescribed tonics, uterine sedatives, rest and nourishment. Five days later found her wasting freely, abortion unavoidable, foetal structures passed off, unable to remove maternal structures manually on account of pain. Used curette forceps and curette, irrigating and disinfecting uterine cavity. Rapid recovery without further wasting, although it had existed for several days, as well as the elevation of temperature.

II.—Called in consultation to see Mrs. L——. Foetal structures having passed off about one week previous, attending physician had been unable to remove maternal structures, although an able physician of years of experience. There being elevation of temperature, evidences of decomposition and absorption. I at once curetted with the usual precautions. Temperature subsided, discharges checked, rapid recovery.

III.—Called to see Mrs. R——, in consultation. Had been flowing some ten or twelve days, attending physician having failed to remove uterine contents. Patient refusing to have curette used, after I had tried to clear uterine cavity with finger, I returned home. After five days of continually getting worse, I

was called again. Cured with the usual result, rapid recovery.

IV.—Mrs. M——, primipara, supposed three months pregnant; thrown from a mule; was called a few days later. Found her with elevation of temperature, excessive nausea, furred tongue, red on edges, tympanites, constipation, pelvic tenderness but no exudate as far as able to detect.

Prescribed rest, opiate viburnum, remedies to quiet nausea, to be followed by carthartic. Patient grew worse, foetal structures passing off some seven or eight days later, placental structures retained. As I could not remove them without instruments, gave usual treatment for two days then cured. Patient gradually improved, inflammatory symptoms subsiding, recovered.

V.—Was called to see Mrs. N——, multipara, in third month of pregnancy, suffering with pelvic inflammation, with exudate surrounding the whole of uterus; four days later general peritonitis developed; five days later foetal structures passed off; patient in a critical condition, temperature 97 degrees Fahrenheit, pulse 135, weak. There being considerable hemorrhage tamponed for fourteen hours, then tried again to remove uterine contents with finger; failing, proceeded to curette. Patient then had a temperature of 96½ degrees Fahrenheit, pulse 130, discharges offensive. Found uterus fixed immovably by inflammatory exudate surrounding it, with a constriction in cavity 2½ inches from os, 1½ inches from fundus; placental structure partly above and partly below constriction, which could be dilated easily with a Goodell-Elinger dilator, but rapidly contracted as soon as instrument was removed. Succeeded comparatively well in emptying uterus, disinfecting thoroughly. Temperature soon reached normal, pulse came down, patient improved rapidly for a few days, when a change of weather came, rain blew in above and below door, wetting carpet, etc.; patient "took cold," began coughing, re-kindled pelvic inflammation, which soon subsided under appropriate treatment, and patient recovered.

Other cases might be presented, but these certainly illustrate

that the curette benefits some cases, and to my mind prevents graver complications.

It may be claimed this curetting is all unnecessary, that a physician should be able to manage all such cases without instruments or that nature can take care of them. I would reply, nature often does not, and the physician who fails to relieve his patient, if need be, with curette and prevent the ebbing away of that "which is the life thereof" and the development of those graver complications and sometimes death, is culpably negligent of his duty.

As to my not being able at all times to remove placental structures from uterine cavity *without instruments*, I do not feel that it is entirely a want of skill, even be it so. I know I have at my command means by which I can do such work more efficiently, with less pain, without anæsthetic or assistant, and with less risk to patient than to allow them to remain. I am also inclined to think that a pelvic inflammation in the conditions under consideration is not always a barrier to the use of the curette. Nay, I believe it is sometimes prevented, if not relieved, by the proper use of the curette.

Certainly I would not claim that where pyosalpinx, ovarian or pelvic abscess exists that curetting the uterus would relieve them, yet I would not fear to curette the uterus, with proper precautions, where metritis, salpingitis, ovaritis, and even where a pyosalpinx existed on one side previous to the pregnancy, if the uterus contained placental tissues keeping up a continual waste, decomposing, and endangering the life of the patient.

A word as to mode of curetting. Put patient on back, using a Hale-Leonardo-Wackerhagen speculum, a variety that expands vulval orifice, allowing space for use of instruments. If patient is in Sims' position use an Erich-Cleveland or some self-retaining speculum, dilating if necessary with steel dilators, never using any form of tents. Irrigate with mercuric chloride 1 in 2,000 to 4,000 or 6,000; curette with sharp or dull curette as the case demands. Again irrigate, being certain to give free exit to all fluids injected. If need be hold dilator in cervix while irrigating. If the stronger solutions are used, follow with sterilized

water to prevent mercurial poisoning, then apply to endometrium pure carbolic acid, iodized phenol, or inject twenty to thirty min. of Churchill's tincture iodine. Remove excess with absorbent cotton, drying vaginal canal. Dust cervix thoroughly with iodoform or boracic acid. Introduce a pledget of borated cotton, with string attached, to be removed in ten or twelve hours, following with copious hot water vaginal irrigation.

I have thus carried out this procedure a number of times, without assistant or anæsthetic, with less pain to patient than removal by any other means, and, I dare say, more efficiently than it can be done with finger and with more satisfactory results.

The operation, performed as above indicated, with aseptic instruments and aseptic operator, will not cause, but prevent, many abdominal sections. Even where salpingitis, ovaritis or pelvic inflammations exist as a result of septic absorption from uterine contents, they will not be aggravated, but lessened, by such a procedure, often preventing abscess formation requiring grave procedures.

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## AN INTERESTING OPERATION FOR OVARIAN CYST.

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By JNO. R. BRADFIELD, M. D., AND FRED'K. M. REEVES, M. D.,  
ALVORD, TEXAS.

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The patient, Mrs. E. C., æt. 42, came to us on the 10th ult., suffering with amenorrhœa, which was partially relieved by the usual treatment, prior to a thorough examination to establish the existence of an ovarian *cyst*, which patient said had been diagnosed as such four years previously, and operative measures for removal were refused, owing to the size of tumor and condition of patient at that time. We were called later and found her in very pronounced hystero-epileptic convulsions, which were finally overcome in the course of six or eight hours, leaving her well-

nigh exhausted. On making a thorough examination, we found, *per vaginam*, a hard immovable cyst lying in the ovarian region—characteristic in fact.

The aspirator showed a small quantity of serous fluid and disorganized tissue.

We were satisfied that the only alternatives were an operation or death, because the tumor was degenerating and no doubt would sooner or later break down and produce death by peritonitis or some other complication. We prepared patient for operation on the 20th ult. After having cleansed the parts thoroughly with 1 to 40 carb. sol., we made an incision sufficiently extensive to allow us room for removal in the linea alba, taking considerable care to leave wound with smooth edges, catching up the bleeding points—leaving nothing to enter the cavity. The tumor, or cyst rather, was laid bare, an assistant clasping edges of wounds down against the surface of the cyst, leaving only sufficient space for making an incision; opened the cyst with one stroke of the scalpel, allowed half the contents, the whole being perhaps a quart and a half, at least, to escape without contaminating the external wound, then passing a strong cat-gut ligature around the thin walls, had it as secure as when intact and much more space to break up adhesions and secure arteries. We severed the fallopian tube three or four lines from the uterus.

After removal we packed the cavity with antiseptic gauze until perfectly dry, there having been very little hemorrhage and no contact with contents of cyst. We then caught up the edges of the peritoneum in the lips of the wound, securing same with large cat-gut sutures at every three or four lines and intermediate silk sutures bringing edges smoothly together. We left drainage tube in lower part. We used a very large quantity of iodoform over the surface generally. Then the dressing was completed with absorbent cotton held by eight-inch bandages, followed, in anticipation of shock, with morphine and verat. viride, and watched the general condition of patient for forty-eight hours, the one or the other attending. The temperature ranged

below 101°; the bowels were "moved" by enemata. The patient bids fair to recover at this time.

The main feature of the case was not the size of the tumor, but its slow progress.

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## NOTE ON THE USE OF SULPHUR PREPARATIONS IN SKIN DISEASES.

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By CHARLES SZADEK, M. D., KIEFF, RUSSIA.

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Sulphur is a remedy of great practical utility in the external and internal treatment of many skin diseases, and although it has been known by the medical profession for nearly two centuries, it has not been very largely employed by modern physicians. My attention was attracted to this drug some time ago, as I have knowledge with paper of Dr. Unna on "Ichthyol and Resorcin in the Treatment of Skin Diseases (1886).

I have for some time employed the sulphur preparations in the form of ointment or powder in my private practice as a remedy in various skin diseases, and in many cases I have obtained very favorable and surprising results. The first case was one of long-standing rosacea in a married lady, thirty-two years old, having a family history which was negative as regarded tuberculosis, syphilis and scrofula; presented herself with a lesion on the face, which, she said, was first noticed about three years ago as small pimples near the middle of the nose. It had spread symmetrically also over the cheeks down to the mouth, passing upward to the root of the nose. The patient had been treated by some noted specialists in this section, and had not been benefited to any extent. The skin affection involved the nose and the cheeks partly; these surfaces were all dark copper-red, with multiple nodules and pustules; the vessels were strongly injected.



I have prescribed an ointment of precipitated sulphur, one part to eight parts of vaseline. After a fortnight's external use of the sulphur, the color of the affected skin-region became much clearer and the eruption began to show the effect of the sulphur treatment. There has not been the slightest irritation produced by the drug. In three months the disease of the skin disappeared and the patient was cured.

In the same way, and with equal success, I have treated another case of erythematous rosacea and some cases of so-called seborrhœic eczema (Unna). I have also found excellent results to follow the use of sulphur preparations in hyperidrosis, whether of the face, hands, axillæ or other regions. In cases of seborrhœa of the scalp an ointment of one part of sulphur to eight to ten parts of oil was the simplest and at the same time one of the most efficacious remedies. I have prescribed the sulphur-ointment in some cases of chronic eczema in children, and in prurigo, ichthyosis, etc., which I have been in the habit of treating by usual methods, and sometimes the results have been very gratifying and satisfactory from the use of sulphur more than from that of other remedies. In the same affections I have used the preparations of ichthyol, as a substitute for sulphur, according to the prescriptions of Unna, externally and internally, and I have also obtained very favorable results. I have not observed any injurious or disagreeable action of the remedy. On the contrary, the internal use of ichthyol, five to ten drops two or three times a day, was followed by increased appetite and powers of digestion.

I have employed the sulphur preparations as in the following prescriptions :

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| <p>1. Take of<br/>           Sublimed sulphur, <math>\frac{1}{2}</math> drachm.<br/>           Salicylic acid, 8 grains.<br/>           Powdered arrowroot, <math>\frac{1}{2}</math> ounce.<br/>           Mix.</p> | <p>3. Take of<br/>           Sublimed sulphur, 2 drachms.<br/>           Ætheris sulphuris,<br/>           Spirits vini rectifi, aa 2 ounces.<br/>           Mix. Sig. Shake well and mop<br/>           over the surface.</p> |
| <p>2. Take of<br/>           Sublimed sulphur, <math>\frac{1}{2}</math> drachm.<br/>           Almond-oil,<br/>           Glycerine, aa 3 ounces.<br/>           Mix.</p>   | <p>4. Take of<br/>           Sublimed sulphur, 2 scruples.<br/>           Vaseline or ointment of benzo-<br/>           ated oxide of zinc, 1 ounce.</p>   |

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| <p>5. Take of<br/>         Ichthyol (sulpho-ichthyolate of sodium or ammonium),<br/>         Spirits vini rectifi, aa 1 ounce.<br/>         M. D. S. Five to ten drops<br/>         two or three times a day.</p> <p>6. Take of<br/>         Ichthyol, 2 scruples.</p> | <p>Powdered oxidè of zinc,<br/>         Powdered arrowroot, aa 2 ounces.<br/>         Vaseline, <math>\frac{1}{2}</math> ounce.<br/>         Mix. f. pasta.</p> <p>7. Take of<br/>         Ichthyol, <math>\frac{1}{2}</math> to 1 drachm.<br/>         Vaseline, or ointment of benzo-<br/>         ated oxide of zinc, <math>\frac{1}{2}</math> ounce.</p> |
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#### CHANCRES OF THE FINGERS.

An excellent clinical monograph on the subject of chancres of the fingers has been published in *N. Y. Medical Record*, January 17, 1891, by R. W. Taylor, accompanied by a chromo-lithograph. He says that chancres of the fingers contracted in operations, examinations and manipulations are not uncommon among obstetricians, surgeons and midwives, and they are occasionally seen upon the hands of some luckless laymen as the result of their handling or lasciviously fondling the infected genitals of some female. They are also observed in dentists, contracted in operations on the mouths of syphilitic patients. They may be seated upon the finger pulp or around the nail. Syphilitic finger infection has been seen in children and women as a result of picking or dressing the hard chancre of a second party. Finger chancres as a result of a bite by a syphilitic person are also occasionally seen. Chancres of the knuckles and fingers have been known to follow a blow delivered upon the mouth of a person suffering from specific lesions. These chancres are prone to form at some part of the nail margin, also on the sides and on the pulp of the finger and along its continuity. In the greater number of cases they are due to the infection of a small fissure, a chap, an excoriation or a cut, or to the lodgement of the virus between the nail and its tegumentary fold. Any skin disease of an inflammatory or hyperplastic nature situated upon the fingers or hands may afford a port of entry for syphilitic infection. For clinical purposes we may divide chancres of the fingers into four forms, as follows: (1) The scaling papule or tubercle; (2) the excoriated or exulcerated nodule or mass; (3) the fungating chancre; and (4) the panaritium form chancre. First form of digital chancre (papule or tubercle form) is the newest and

simplest in character, and is the rarest of all forms observed on these members. It is usually found upon the dorsal surface of a phalanx, and occasionally it is seated upon the palmar surface or the sides of the fingers. It usually begins on the site of a slight cut, an excoriation or a fissure. The traumatic lesion may or may not heal and disappear. The chancre begins as a small red spot, which may or may not be scaly. This spot usually grows quite promptly, and in about a fortnight a round or oval papule or papulo-tubercle is formed. Thus it may remain in an indolent, slightly scaly state or it may extend. The scaling papule may exist for weeks, or two or three months, and then it sinks down and disappears, leaving a thickened, more or less purplish or brownish red pigmented site, which may or may not be the seat of induration or of more or less atrophy. The excoriated or exulcerated form of digital chancre is usually found toward the end of the finger, and to have its origin in some lesion of the nail margin, which may be an excoriation or fissure, a hangnail or even some slight separation between the skin and the nail inappreciable to the naked eye. The exulcerated nodule usually begins as a small pustule or as a minute, red excoriation of varying shape. This latter lesion increases quite rapidly in area and in height, and is, in its early days, indolent and painless. It may reach only to small size, but usually the hyperplasia is luxuriant. Full development may occupy a period of two to four weeks. The shape of the lumpy mass depends on its situation. If seated on one side of the finger it may jut out from one-half to one inch. If both sides of the finger are involved, the mass may become as large as a horse chestnut. The course of this chancre depends entirely upon the manner in which it is treated. If kept free from irritation and at rest, it will slowly subside, but if irritated its duration is indefinite. The author has seen one case which has existed for nearly a year. Their chronicity is an important matter, for it carries with it danger of infection to others. Third form of digital chancre, the fungating ulceration, is a not uncommon one, and begins in a moist or dry red spot, or a pustule upon the seat of some traumatism; then, generally, granulations begin to spring up and the surface of the chancre

becomes fungating. They are usually of a dull bluish or purplish red color, and may also resemble in some cases *condylomata lata*, which have become vegetating. These fungating chancres sometimes run an indolent course, showing little, if any, tendency to healthy action. Under proper treatment the granulations give place to a healthy healing surface. There is commonly more or less deformity left by these chancres. Either the nail is more or less permanently destroyed or a retractile and perhaps fibered red or purplish red scar is left which constitutes a permanent deformity. Phlebitis and lymphangitis of a new, even decided type, may be an accompaniment of this chancre at some period of its existence.

The panaritium-like chancre of the finger is not very common, and is seen with rather more frequency than the scaling chancre of the finger, and less frequently than the ulcerated nodule or the fungating mass.

This form of chancre of the fingers usually begins on the integument of the nail margin or in a cut, a fissure, a hangnail, or in some simple inflammatory lesion, which confines itself pretty closely to the nail sulcus, along which it creeps and develops. With the increase of the specific perionychia the distal phalanx begins to swell, and the finger becomes distorted. As the hypertrophic process increases ulceration is usually seen around the nail, to which it may be limited in a crescent-like form. This ulceration usually has an unhealthy, foul surface, secretes a copious, foetid pus, and may be covered in whole or in part with a brownish black or green necrotic film or membrane. The nail rapidly becomes darker, until it is detached as a black looking, foul mass, under which the ulceration has extended. In this state of full development this panaris-like chancre may remain for a long period without any tendency to heal, and sometimes without any evidence of exacerbation. Under proper treatment, however, it will slowly subside, and in the course of several months the end of the finger may be nearly normal in size. Sometimes it becomes much atrophied and pointed, and the seat of an irregular cicatrix. In most cases the nail is impaired, sometimes wholly destroyed, and sometimes only partially

so. This form of finger chancre may be mistaken for non-specific panaritium, and for the early and later perionychiæ of syphilis. Accompanying the panaritium-like chancre a mild or severe phlebitis or lymphangitis may occur. The author reports three cases of digital chancre, in which pyemic and septic infection occurred. In two cases, it is probable that the agent of infection was the streptococcus pyogenes of Rosenbach. The history of the third case is very interesting and peculiar. In this case there was no pre-existent chancre, but syphilitic and septic infection took place simultaneously through the entry of the secretion of a phagedenic chancre into a minute healthy wound on the woman's finger.

The fact of the not uncommon occurrence of chancres upon the fingers of surgeons, physicians, and midwives suggests to us the danger of syphilitic infection to their patients. Cases of syphilis transmitted by finger infection in medical and obstetrical practice are sufficiently common and well attested to warrant us in a consideration of the question of prophylaxis. It is evident that surgeons afflicted with syphilis are much less liable to infect their patients than obstetricians, particularly in these days of thorough asepsis and antisepsis. The period of greatest danger from finger infection by medical men is in the early days of the chancre, when it is small and well, and its nature is not suspected. In this period it is very little, if at all painful; it has not an angry or an inflamed look, but, on the contrary, present a benign, even insignificant, appearance.

(*Medical Record*, New York, 1891, I, 3, pages 69-73).

## Society Reports.

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### GYNECOLOGICAL AND OBSTETRICAL SOCIETY OF BALTIMORE.

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March meeting.

DR. HENRY W. WILSON, President, in the chair.

DR. HOWARD A. KELLY read a paper on the technique of the Cæsarean section, described in a series of steps, from the selection of the case down to the after treatment. The relative and absolute indications were described. The Porro operation was rejected, excepting under special peculiar circumstances ; for example, when there was good reason to suspect septic infection, as after prolonged efforts at delivery, at turning, or the use of the forceps ; also in cases of large tumors occupying the body of the uterus, or in some cases of cancer, or in uncontrollable hemorrhage from the placental site. Thus limited, the conservative operation and the Porro operation are mutually exclusive, not occupying the same field.

It is a serious surgical error to mutilate a woman by performing the Porro operation where special indications do not exist.

The mortality of the Porro operation is fully as great and probably greater than that of the conservative.

In a healthy case, free from sepsis, with unruptured membranes, it is not necessary to deliver the uterus from the abdomen before incising it and delivering the child. It is rarely necessary to use any constricting ligature around the cervical end of the uterus. Excessive hemorrhage from the placental site or the margin of the wound can very well be temporarily controlled by constricting the cervix with the hands of an assistant.

The uterine suture consists of deep sutures, embracing the peritoneum and muscularis, but not the decidua. About ten such

sutures are needed. Between each of these deep sutures, half deep sutures can be passed, securing perfect coaptation of the peritoneal surfaces. The sero-serous sutures are not necessary in cases free from any suspicion of infection. In such clean cases, the uterus is dropped back into the abdomen and covered with the omentum. If there exists a slight suspicion, it is of advantage to draw the omentum down behind the uterus, thus favoring the discharge of any septic material through the lower angle of the wound.

Drainage of the pelvic cavity cannot be efficiently carried out. The abdominal wound must be concealed by a dressing of snowy cotton dissolved in alcohol and ether, containing one part bichloride to 16,000. A little strip of gauze is laid over the wound saturated with this solution. This adheres until it is time to take the sutures out, concealing the wound and preventing contamination from the outside much better than many layers of gauze and cotton. The baby should be allowed to nurse as soon as the mother has thoroughly recovered from the anæsthetic.

The vagina should not be douched out as a matter of routine. The vaginal outlet should be secured from the introduction of sepsis from without by separating the labia and throwing into the vulvar orifice a drachm of powdered iodoform and boric acid (2 to 7). A cotton pad loosely applied to the vulva should be changed as often as soiled by the discharges. The patient thus passes through a perfectly normal puerperium.

DR. CHAS. P. NOBLE : In the technique of the operation laid down by Dr. Kelly, reference has been made to typical cases. In such cases I agree entirely with what he has said. But all cases are not typical. I will report an unique case upon which I did the Cæsarean section recently.

Dr. Kelly had operated in a previous pregnancy. As a result of the previous operation there remained a fistula opening from the uterine cavity through the abdominal wall. Notwithstanding this fistula, she became pregnant, and for several weeks the amniotic bag protruded into the opening, so that there was

nothing between the foetus and the outer world but the thin amniotic sac.

This sac ruptured at the thirty-third week. The woman had a generally contracted pelvis, besides having a large mass of scar tissue behind the cervix, left from her previous Cæsarean labor. Had spontaneous labor been possible, the foetus would have escaped through the fistula and not *per vaginam*. In view of the conditions, I thought Cæsarean section preferable to delivering the mutilated foetus *per via naturales*.

The finger was inserted into the uterus through the fistula, and, with this as a guide, the incision was made through the region of utero-abdominal.

Sufficient room not being afforded for delivery, the peritoneal cavity was opened and the uterine incision lengthened. The living foetus was then delivered.

The placenta and membranes were firmly adherent, and were closely peeled off. To control bleeding during this time it was necessary to insert the uterus through the abdominal incision, to enable the assistant to grasp the lower segment.

The patient passed through a perfectly normal puerperium, and is now quite well and soundly healed.

This case is entirely unique in its condition and in the technique of the operation.

Three cases of Cæsarean section have been observed by me, all having made good recoveries. When the operation is done at the proper time, and after the method described by Dr. Kelly, I am sure this result will be quite uniform.

The essentials of success are:

1. Operation at the proper time, before labor, or at the beginning of labor.
2. Rapidity in operating.
3. Accurate suturing.
4. Asepsis.

With reference to suturing, I believe that the Lembert suture, as ordinarily described, is purely theoretical. The peritoneum will not hold a suture. Operators have unconsciously included the deeper tissues in the so-called Lembert suture. An important



point, not generally recognized in country, is, that the diagnosis should be made in the last weeks of pregnancy, and under ordinary circumstances the operation be decided upon and done at the close of pregnancy before labor sets in, or immediately thereafter. I would not do the modern Cæsarean section in a case which had been tampered with by efforts to deliver with the forceps or by version ; but in such cases would prefer the operation. In Philadelphia in the last four years, twelve Cæsarean sections have been done, and ten mothers have recovered. One that died had pneumonia at the time of the operation. The other case was one in which the surgeon at the same time removed a fibroid tumor.

DR. B. B. BROWNE: I think all the procedures recommended are in the main correct, and are in accordance with the rules and suggestions laid down five or six years ago by Garrigues, Sænger and Leopold. These should be carried out in ideal cases, but unfortunately we meet with many complications which must be dealt with as they occur.

Having recently performed the operation myself and looked up the literature and technique of the subject, I was surprised to find that we can to-day make but little improvement or change for the better.

In 1886 Sænger had operated four times, saving all the women and children. Dr. Leopold had operated nine times and lost one woman, saving all the children.

DR. T. A. ASHBY: I wish to congratulate Dr. Kelly on his brilliant success with the Cæsarean section. This success is convincing proof of what can be done when the section is instituted under proper conditions and at a proper time.

The future of the operation rests upon a proper and judicious selection of the case, and upon an immediate resort to the section before other methods of delivery have been attempted and abandoned.

I doubt whether the Cæsarean section, under such conditions, will give a higher mortality than the ovariectomy of ten or fifteen years ago.

The technique of the section is simple enough, and certainly

its mechanical execution is not as difficult as that necessitated in the removal of many conditions of tubal and ovarian disease.

Hemorrhage is not large, and it is easily controlled. Septic processes should not follow if strict aseptic precautions are observed.

The progress of the section as a substitute for other methods of delivery, rests upon an early and clear recognition of the pelvic measurements and a prompt acceptance of this method as the proper procedure in the given case. When this is done the success of the section is not compromised by unfortunate interferences in other directions. When we have obtained the statistics of this class of cases, we are in a position to compare the mortality of the section with other operative methods.

DR. W. P. CHUNN: I did not hear the first part of the history of the case, but think I would have removed the ovaries or tied the Fallopian tubes to prevent future conception. It is hard to say just what operation should be done.

DR. NOBLE: In doing a Cæsarean section I would not touch the ovaries and tubes as Dr. Chunn spoke of doing, but would do nothing to prolong the operation. Tying of the tubes would probably cause salpingitis. This objection is purely theoretical. So far as I know this has been done only twice—once in England and once in America.

DR. BRINTON: I have been for some years interested in measuring the pelvis of women. Very often we go to labor cases without knowing anything about the condition of the pelvis.

With the hospital surgeon, who has the best facilities, the Cæsarean operation will undoubtedly be the best in cases of extreme pelvic contraction. But with the average practitioner what is best? I think that, with these physicians, craniotomy will hold the place.

In speaking of craniotomy "holding its place," I referred to those cases of pelvic contraction when the child could be extracted without harm to the mother, say from  $1\frac{3}{4}$  to 3 inches.

DR. T. A. ASHBY: I must offer an apology for presenting a series of experiences which are familiar to all who have done much intra-abdominal work.

I have brought these charred remnants of tubal and ovarian inflammation before the Society to invite discussion, not to exhibit anything original. They represent nearly every phase of intra-pelvic inflammation, and illustrate the various degenerative conditions which are found in the pelvis after an inflammatory fire has passed over these tissues. Of the nine specimens here presented, removed from the same number of cases, no two are alike.

In one case the tube has received the brunt of the attack; in another the ovary is involved in abscess cavities, whilst in the third both tube and ovary are tied up in a knot of adhesive inflammation, and so on through the series.

The clinical histories of these cases would be exceedingly interesting did time admit of a recital, but I shall not tax your patience with details.

We have the same old story in all of these cases save two—one the large specimen of a tubal sac of uncertain origin, probably an interrupted tubal pregnancy of long standing, and the other the remnants of a catarrhal salpingitis and ovaritis with intra-pelvic adhesions. Of the other seven specimens the origin of the condition is of chief interest in this connection, since they explain to my mind the essential factor in the production of the specimen here presented. Each of these women have borne one or more children; in each case the history of the intra-pelvic trouble dates from the last lying-in period which was accompanied with mild or severe symptoms of child-bed fever. In each of these women there was an old lacerated cervix, in some more pronounced than in others. The histories of these cases, as far as they can be made out, and can be interpreted, tell the simple story. During labor a cervical tear occurred; in this wound septic material gained a lodgement, a septic process was established which extended from the cervix to the cavity, from the cavity to the tubes and from the tubes to the intra-pelvic peritoneum.

The severity of the symptoms in each case must have borne some relation to the septic process and to the tissues involved, though no way is offered for verifying this statement. We

simply find the results in general destruction of the tube or ovary, or of both, and the inference is that drainage was severed and pus escaped, leaving no remnants of this character behind except in two of the specimens, in which I found pus cavities in the ovary, containing each a drachm or more of pus.

These cases illustrate the fearful havoc which a septic process following parturition may occasion among the pelvic organs. A little fire kindleth a mighty conflagration is literally true in more respects than one. In an experience with other cases I have observed this septic process in its very beginning when limited to the cervix and cavity, and I have seen the lying-in woman's temperature fall from 103 degrees to normal within twelve hours after thorough cleaning and disinfection of the cervix and cavity in these cases, and a complete arrest of the process before the tubes were involved. In another case I have seen tubal and general pelvic peritonitis in active force following immediately the injections in the cervix and cavity. This experience convinces me, despite all other theoretical teachings, that we have in the lying-in state an explanation of those intra-pelvic diseases which render the lives of so many women useless and oftentimes utterly miserable. How is it necessary that the lying-in period should be surrounded with extra hazard, high temperature and severe pain. Aseptic endometritis following parturition may run a very mild and low grade course, and still result in subinvolution, salpingitis, pelvic adhesions, and other intra-pelvic conditions which impair the normal functions of these organs.

The lesson clearly taught by such experience is that aseptic conditions should be enforced in every case of labor; that the least suspicion of sepsis should lead to immediate investigation of the uterine cervix and cavity with a view to thorough cleaning and arrest of the septic process. If this be done—as I have done it in a number of cases, seen with medical friends in consultation—we can cut short a sepsis and arrest a condition which will surely extend to the tubes and pelvic peritoneum in the absence of prompt attention.

DR. B. B. BROWNE: The fact that laceration of the cervix is so frequently found in married women suffering from tubal dis-

case is, I think, because the purulent discharge from the uterus passing over the torn surfaces prevents their union, while the septic material also extends to the tubes. When there is no septic material in the uterus the lacerated surfaces readily unite, and the tubes are not affected.

DR. J. WHITRIDGE WILLIAMS: The specimens exhibited represent a class of cases that are very common, and which will become more so as we become more expert in bimanual examination. Indeed, to a skillful palpator it almost seems that the majority of women examined have more or less tubal or ovarian disease. The specimens are particularly interesting to me because I have studied carefully the pathology of a large number of similar cases.

The etiology in many cases is doubtful, but most observers appear to cling to Noegerrath's theory of latent gonorrhœa. Examination of the pus in cases of pyosalpinx brings forward most interesting facts. For in most cases it is impossible to discover any species of bacteria, either under the microscope or by culture methods, which shows that the bacteria which caused the trouble have long since died, for closed pus cavities are not particularly favorable for the growth of organisms. In two cases we found undoubted gonococci, and in a case following an imperfect abortion the streptococcus, and in another case the staphylococcus aureus.

Clinically, the cases due to the pus organisms are much more acute and virulent than those due to the gonococcus. These results correspond with those of Zweifel, of Leipzig, who has just published his observations. He also found the gonococcus and streptococcus, but not the staphylococcus. In one of his streptococcus cases the subject was an undoubted virgin, and he accounted for the infection by an abscess following an attack of typhoid fever some years before.

DR. ASHLEY speaks of the relation of lacerated cervix to salpingitis, etc. I cannot consider it a factor in the production of the disease, and regard it merely as a coincidence. If it were a potent factor in producing the trouble we should find salpingitis and pelvic adhesions far more frequently than we do

now; for we must remember that in most women there is more or less laceration of the cervix during labor. Moreover this cause is certainly inapplicable to the frequent cases occurring in nulliparous women, and especially in virgins.

A close study of the clinical history of a number of cases inclines me to believe that the majority of cases follow infection during labor or after an incomplete abortion, for in many cases it is impossible to obtain even a history of leucorrhœa before the labor, which would apparently exclude gonorrhœal infection.

By infection during childbirth, I do not necessarily mean the cases in which we have well marked puerperal fever, but the milder degrees of infection as well; for most of the cases of so-called milk fever are due to infection and may give rise to serious results.

Zweifel, on the contrary, who has just published a remarkable series, 79 salpingo-oöphorectomies, with only one death, believes in the gonorrhœal origin of most cases. Sænger traces most of the cases in virgins back to a gonorrhœal salpingitis during childhood, which has persisted and ultimately affected the fallopian tubes. While I do not feel justified in subscribing to this view, I can say that it is quite probable.

For lately I have seen a number of cases of undoubted gonorrhœa in little girls of from two to seven years of age, in which there was no suspicion of criminal action.

In eight cases of vaginitis in little girls which I have examined, I found gonococci in six of them. In several, the mode of infection was quite clear. In one case the husband acknowledged an attack of gonorrhœa with which he infected his wife during her pregnancy, and each of the children born after it had ophthalmia neonatorum, followed, when they were older, by gonorrhœal vaginitis. In another case, an older brother had gonorrhœa and his two little sisters used his towels for bathing.

These remarks will show that the vaginitis of little children is not of strumous origin as is generally supposed, and that it demands a more active treatment than is generally employed, especially when we consider its possible consequences.

DR. BRINTON: I can corroborate the views of Dr. Williams,

in regard to the specific origin of the cases of vaginitis in children, having recently treated first, the father with gonorrhœa, later the mother, and within a fortnight from the time the father consulted me was called to see the little daughter, aged four, with a severe "vaginitis" which yielded to the usual treatment in about the usual time. My experience has been that, if a child is found with a "vaginitis" close investigation will prove that some older member of the family has either "urethral" or "vaginal" discharge.

DR. NOBLE: Dr. Ashby has brought up so many points that it is difficult to know just what to take up.

It is now the fashion to call all unilateral collections of blood extra-uterine pregnancies. But I have recently had a case that proved not to be a pregnancy. With reference to the uterine hemorrhage coming from the tuber, we do know as a fact that it is possible for blood to come from the tuber. This was common to all in the days when the stump was treated by the extra-peritoneal method, in doing ovariectomy. I am quite sure that gonorrhœa has been the cause of most of the cases of pyosalpinx that I have seen. And I think that the cause of salpingitis in young women is often some simple infection. Many cases of dysmenorrhœa in young women are due to salpingitis. In such cases it is unnecessary to question their chastity. I agree with all the speakers in reference to the relation of lacerated cervix to salpingitis.

Where there is a laceration there is frequently an endometritis, and there is no reason to think that it may not follow out into the tube. I believe firmly in the great value of the drainage tube, and use it in almost every case. When properly cared for it is practically free from objection, while being of most positive advantage in allowing the escape of serum and blood.

DR. H. P. C. WILSON: I did an exploratory laparotomy for a fibro-cystic tumor. In manipulation I found great tendency to bleeding, and as I could not get at the ovaries nor remove the tumor without causing death, I closed the abdomen. She got on well for fourteen hours, when she became very feeble, heart and respiration very weak. She was put upon digitalis and

muriate of quinine and urea, but it did no good. The heart became so weak that the pulse could not be felt. Then began with five minims of tincture of strophanthus every three hours, and ether m. xx, hypodermically every three hours. The pulse became stronger, 125 to the minute, and she felt better. The next day she became unconscious, pupils dilated, face flushed, pulse 120, temperature normal. The medicine was withdrawn, but she remained in this condition about twenty-four hours. To-day she is better, consciousness returning, pupils contracting. I have had no experience with the poisonous effects of strophanthus.

WILLIAM S. GARDNER, M. D., Secretary.

712 N. Howard St.

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## TENNESSEE STATE MEDICAL SOCIETY.

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The fifty-eighth annual meeting of this Society was held in Nashville, April 14th, 15th and 16th. The meeting was one of the largest in the history of the Society, there being about 150 delegates in attendance.

The following exhibits were made: Horlock's Malted Milk, Tarrant & Co.'s Hoff Malt Extract, Fairchild Bros. & Foster's Digestive Ferments.

On the first day, after the usual preliminaries and invitations to visit various institutions, the Secretary presented his report which showed a membership of 342.

The Treasurer's report showed that the Society was in a good financial condition. There was some difference between the Treasurer and the Secretary, owing to the fact that the latter had received dues from certain members who should have been suspended in accordance with the by-laws. This created quite a breeze, but the matter was finally adjusted amicably.

Dr. Frank Trester Smith appealed from the Publishing Committee on account of their leaving out of the transactions of



1889 the description of certain inventions which the Society at that meeting ordered to be printed, but which, through some misunderstanding, were omitted.

The paper was referred to the new Publication Committee.

Dr. J. F. Grant was elected an honorary member for life. Dr. Grant was a former president of the Society.

Dr. Thos. L. Lipscomb, of Shelbyville, was invited to a seat on the right of the President. He is one of the oldest members of the Society, having missed but few of its meetings since the organization fifty-eight years ago.

One of the most enjoyable sessions was that of the night of the first day, when a musical and literary feast was spread for the benefit of the Society. Dr. J. D. Plunkett, of the Committee of Arrangements, presided, and announced that the meeting was held for the purpose of welcoming the doctors to the city. After prayer by the Rev. Jerry Witherspoon and some instrumental music, Mayor Lutterer was introduced, who welcomed all to Nashville.

Mrs. A. H. Stewart then sang "Heaven Hath Shed a Tear," which was well received and encored.

Gen. H. H. Norman then welcomed the Society on behalf of the Governor who was prevented from being present on account of illness. Judge J. M. Dickson was then introduced, and welcomed the Society on behalf of the citizens. Then followed the address of the evening by the President of the Society, Dr. Geo. A. Baxter, of Chattanooga: "Topics of Import to the Medical Profession." The above interspersed with music, instrumental and vocal, formed a most enjoyable programme.

The following is a list of papers read at the various sessions:

Report of State Board of Medical Examiners.—T. J. Happel, Trenton.

Ovulation and Menstruation.—Geo. R. West, Chattanooga.

Preparatory Treatment of Parturient Women.—C. W. Beaumont, Clarksville.

Posology.—W. M. Vertrees, Nashville.

Treatment of Wounds of the Cranial Sinuses.—W. T. Briggs, Nashville.

A Plea for Early Operative Interference in Ovarian Tumors.—J. H. Blanks, Nashville.

The Treatment of Pneumonia; Past and Present Methods; Has the Mortality been changed?—Thos. M. Woodson, Gallatin.

Phthisis Pulmonalis; with Special Reference to Prophylaxis.—J. R. Buist, Nashville.

The Anatomy and Pathology of the Ileo-Cæcal Region.—Richard Douglass, Nashville.

Urethral Stricture.—J. W. Handley, Nashville.

Abscesses.—T. J. Happel, Trenton.

Has Progress been made in the Treatment of Typhoid Fever?—C. M. Sebastian, Martin.

Chronic Endometritis.—J. S. Cain, Nashville.

Retention of the Placenta of Miscarriage; How Shall We Treat such Cases.—A. J. Swaney, Nashville.

Indigo as an Emmenagogue.—J. L. Jones, Bells.

Diabetes.—J. A. Witherspoon, Columbia.

Dr. W. Whitford, Chicago, acted as official stenographer.

The following officers were elected:

President—J. W. Penn, Humboldt; Vice-Presidents—J. A. Witherspoon, Columbia; C. H. Lovelace, Dukedom, and C. E. Ristine, Knoxville; Secretary—D. E. Nelson, Chattanooga; Treasurer—J. P. C. Walker, Dyersburg.

The next meeting will be held in Knoxville, on the second Tuesday in April, 1892.

FRANK TRESTER SMITH.

NATIONAL STERILITY.—In France in 1888 there were 882,639 births and 794,933 deaths. The rate of births has fallen from 30 per 1,000 in the early years of the century to 23 per 1,000. The number of marriages has fallen to 7.1 per 1,000, and the number of births to each family has fallen to 3. Divorces are increasing in frequency, especially among the educated classes, while the tendency is for marriage to take place later in life.—*The Journal, Little Rock.*

## Correspondence.

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### OUR NEW YORK LETTER.

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NEW YORK, MAY 16, 1891.

#### TUBERCULIN.

At the last meeting of the Academy there was presented the most satisfactory report of the use of the Koch remedy in the hospitals of this city which has yet appeared. Dr. Kinnicutt, of St. Luke's, read the first paper. He stated that fifty-two cases had been treated at that hospital. Of these thirteen were pulmonary and six laryngeal and pulmonary combined. His experience had taught him that the solution should be freshly prepared at each injection, as the usual carbolized preparation soon deteriorated. The subsidence of the local and systemic reactions, as shown by the physical and general signs, was the best guide in determining the advisability of a repetition of the dose. The action of the remedy imitated admirably nature's method of cure by softening, gradual elimination and sequestration.

He divided his pulmonary cases into three groups. In the first of these local and general improvement occurred, in the second there was no improvement, and in the third decided deterioration. Five cases were included in the first group. Their ages varied from seventeen to forty-two years. In three of them a family predisposition was discovered. In two there had been hæmoptysis. Sputa containing bacilli were present in all the cases, and the physical signs showed infiltration of the apex of one lung. Three cases were under treatment for eleven, thirteen and sixteen weeks respectively, and the maximum doses which they received were sixteen, nineteen and twenty-one milligrammes. There was a gain in weight of fourteen pounds in two

cases and of eleven pounds in a third. Two cases were still in the hospital and had gained in weight eight and one-half and four and one-half pounds respectively. The physical signs indicated improvement in the local conditions, and the number of bacilli in the sputa were diminished.

The improvement in these cases had been notable, greater than had ever occurred in the hospital under any other plan of treatment.

Cod liver oil and creosote had been used in connection with the Koch remedy. They had been used alone on the same cases, in one instance for a year, without benefit.

Four cases appeared to be injured by the remedy ; in one an excavation occurred very rapidly after its use was begun.

The impressions which he had gained from five months of observation could be summed up as follows :

1. Tuberculin possessed marked elective tendencies for tubercular tissue.
2. Its value for the purposes of differential diagnosis was relative, not positive.
3. It should be given at first in very small doses, which should be increased gradually.
4. Its use in pulmonary cases should be restricted to the early stage.
5. It was impossible to predict its effect in any case.
6. The constitutional tolerance of different individuals varied.
7. The amount of local reaction was fairly well indicated by the temperature curve.
8. The remedy excited a pneumonic process.
9. Hæmoptysis due to its use was rare.
10. Its use entailed great watchfulness and anxiety on the part of the physician.
11. In the early stage of pulmonary tuberculosis it effected a greater degree of improvement than any other method of treatment.

Dr. A. L. Loomis reported briefly the results obtained at Bellevue Hospital. He stated that thirteen pulmonary cases had

been treated there. Of these, eight were in the first stage. The general condition of these eight improved, there being an average gain in weight of eight and a half pounds. The number of bacilli in the sputa diminished in all but two cases. The usual result of the treatment consisted of an apparent increase in the activity of the disease, after four to twelve days of treatment; this was followed in about two weeks by a decrease. One case died of disseminated tuberculosis, the *post mortem* revealing tubercles in all the organs. Another became manifestly worse. Of the three cases in the third stage, one died; the others gained thirteen and three-fourths, and nine pounds respectively. There was no change apparent in the cough and expectoration, but in one case the sweats ceased. The conclusions which he had arrived at were :

1. Tuberculin was capable of exciting very active changes.
2. Its effect depended on the amount given, and on the frequency with which the dose was repeated.
3. If too much was given, rapid extension of the disease resulted.
4. The initial dose should be small, varying from one-tenth to one milligramme.
5. The pneumatic cabinet was a valuable adjunct to the treatment.
6. The number of bacilli in the sputa was no criterion of the effect of the remedy. They might not disappear, even though cure was accomplished. In cases apparently cured by other plans of treatment, bacilli had been found as long as ten years after all other traces of disease had disappeared.
7. In some cases tuberculin aggravated the disease, two cases of general tuberculosis having resulted.
8. Larger and more carefully acquired experience was necessary to secure the safe and proper use of the remedy, but it was destined to take a permanent place in the treatment of tuberculosis.

Dr. N. H. Heineman, of the Mt. Sinai Hospital, believed that the aniline colors would eventually prove valuable adjuvants to the Koch remedy.

Dr. E. L. Trudeau, of the Sanitarium for Consumptives in the Adirondacks, stated that eight cases had been treated there by tuberculin. Of these one was cured and one improved.

Dr. Jacobi said that every case must be treated tentatively. Sixteen pulmonary cases had been treated by him, of whom one died, four were not improved, five improved, four improved very much, and two recovered.

Dr. S. Baruch had seen three cases recover under the use of tuberculin, at the Montefiore home. He was unable, however, to attribute any special value to the remedy in these cases.

#### ANILINE DYES FOR CANCER.

Dr. Willy Meyer, of the Skin and Cancer Hospital, has been treating a number of inoperable malignant growths with Merck's Pyoktanin, or purified Methylene blue. The treatment was introduced in Germany, where it was discovered that the application of a powder, composed of pyoktanin one part, and talc a hundred parts, was successful in checking the growth of a cancerous ulcer of the breast. Nine cases were treated at the Cancer Hospital, the pyoktanin being applied in the form of powder and ointment of the strength of 1 to 200, and as parenchymatous injections of a solution of 1 to 300, every second day until the fifth injection, when the treatment was discontinued. A maximum dose of a drachm and a half of the solution was innocuous to the general system, the only symptoms observed being nausea, vomiting, weak and slow pulse, headache and general malaise. The local effects were œdema, pain and breaking down of the injected tissue, with perforation of the skin, and discharge. The disease was perhaps not all removed, but much good was accomplished, and this might be improved upon.

#### RELATIONS OF NASO-PHARYNGEAL CATARRH TO GASTRIC CATARRH.

At the last meeting of the Academy Section of Pædiatrics, Dr. Fischer read a paper in which he took the ground that gastric catarrh was a frequent result of the presence of naso-pharyngeal catarrh, from the septic matter and alkaline mucus swallowed, and from the continuity of the mucous tract. This was especially

true in children under two and one-half years of age, as they did not expectorate.

Dr. Jacobi stated that, although it was true that a close connection existed between the pharynx and the stomach, he had been accustomed to regard catarrhs of both as rather coincident or co-ordinate. They were rather parts of one symptom, the tendency of a mucous membrane being to become inflamed over a wide area. It was possible that pharyngitis might be regarded as a cause of gastritis, but, as a rule, the stomach, accustomed as it was, to the reception of many different substances, some of which were irritating, was perfectly able to deal with the quantity of septic discharge of alkaline mucus which might be swallowed.

Dr. W. P. Northrup has observed that in cases of recovering diphtheria the naso-pharyngeal mucous membrane discharged large quantities of pus, much of which was swallowed. Gastritis was not common in such cases, however, and he was inclined to differ from Dr. Fischer's opinion of the causative relation of naso-pharyngeal catarrh.

#### DENTITION AS A PATHOLOGICAL FACTOR.

At the same meeting Dr. A. Brothers read a paper on the relation of dentition to various pathological conditions. He stated that formerly all ailments occurring during dentition were ascribed to its influence. Now the pendulum had swung in the opposite direction, and the tendency was to ignore it entirely. He had made observations of five hundred cases, making careful notes of his observations. He had found that the average age at which the first teeth appeared was six and a half months. In a few cases they were congenitally present. Precocious development was not uncommon, and in twenty-one and a half per cent. of the cases the first dentition occurred in the upper jaw. The effect of artificial feeding, wholly or partially, was retarding. In such cases the first teeth sometimes appeared early, but those following were always retarded.

All congenital diseases, such as premature ossification of the skull, heart disease, congenital syphilis, tuberculosis, and deficient mental development and meningitis, caused delay.

Of the diseases acquired during infancy rachitis, it was well known, had a retarding influence. In one-half of his cases with this disease teething did not begin until the child was a year old. Scrofulosis, on the other hand, produced precocity, teeth appearing at an average age of six months. Chronic bronchitis, whooping cough and lung diseases caused delay. Teething was precocious in epileptics, and also in marasmus cases so far as the first teeth to appear were concerned; those coming later were retarded. The diseases which could be traced to dentition were few. He had seen stomatitis thus produced, in some cases pustules appearing in the gum above the emerging tooth. Neuralgia occurred occasionally, but its existence could seldom be determined positively. Fever was seldom due to dentition; in numerous cases in which the child was said to be "fevered," the thermometer showed no change in the temperature. He had never seen meningitis from this cause. He believed that convulsions were a possible occurrence, but only exceptionally. He had never seen paralysis from teething. Blenorrhœic inflammation of the eyelids was regarded by some as an effect of teething; he had not been able to convince himself that this was a fact. Neither had he seen suppurative ear affections from this cause, although Solis-Cohen claimed that one-third of the cases in scrofulous subjects followed teething.

Diarrhœa during dentition was regarded by some as physiological. We know now that diarrhœa is caused by micro-organisms in the intestinal canal, and that it seldom accompanies dentition except in the summer months.

Dr. J. Lewis Smith said that he had seen a case in which spasmodic contraction of one set of muscles seemed to be caused by dentition, as it disappeared after five teeth had been cut, and no other cause could be discovered. He doubted if delayed dentition could ever be regarded as normal, and in such a case a suspicion of rachitis should be aroused.

Dr. Jacobi had never seen gastritis result from dentition. He agreed with Dr. Smith that delayed dentition was never normal, but, as in the cases where mixed and artificial feeding were resorted to, indicated a defect in nutrition. He would so regard all cases



even when they embraced whole families of apparently healthy children. When teeth were present at birth, it was better to extract them. They usually came out soon and were not settled in the bone, but were merely attached to the connective tissue.

#### ATROPINE IN ENURESIS.

In the last number of the Archives of Pædiatrics, Dr. C. G. Kerley, Resident Physician of the New York Infant Asylum, gives some striking results of the use of atropine in twelve cases of enuresis. Nine of the cases were boys and three girls. Their ages were from four to ten years. They wet the bed two or three times during the night, and three of them wet their clothes once or twice during the day also. The custom in the institution is to put the children to bed at seven, and take them up at ten to urinate. No change was made in the case of the children under treatment.

The plan of medication adopted was to put one grain of atropine in an ounce of distilled water. Of this half a drop for every year of the child's age was given at four and at seven P. M. If there were no unpleasant symptoms the dose was increased to one drop. There were slight physiological symptoms of the drug in three cases. After using the remedy for six weeks slight improvement was noticed in four cases; they went one or two nights without wetting. At the end of the third month these four wet but once or twice a week. Seven were practically well at the end of the fifth month, but the treatment was continued for two months longer, when the dose was reduced one-half. Two months later it was discontinued, and now, nine months after, there had been no return.

The remaining five were slightly improved at the end of the fifth month. During the next three months they continued to improve gradually, and at the end of the eighth month they were not wetting the bed oftener than once or twice a week. During the tenth they wet only occasionally, and the dose was reduced one-half. There was no wetting by the end of a year and the treatment was discontinued. The doctor closes by saying that "eighteen months ago we had twelve bed-wetters of the worst type; to-day they are all well, and the only medicine used was atropia."

WM. L. RUSSELL.

151 East 50th Street.

## Editorial.

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### MEETING OF THE AMERICAN MEDICAL ASSOCIATION.

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The recent meeting of the Association at Washington was a notable one in many particulars. And, while the meeting could not be called a truly representative one of the profession of this country, there were eminent men in attendance from all parts of the United States. The attendance was largely from the Western States, while from the East and South the attendance was very meager.

The entire representation, however, displayed abundant zeal for the advancement of the medical sciences and the elevation of the medical profession.

There is a determination on the part of the profession, as a body, to elevate the standard of medical education and to frown down and out of existence those medical colleges which do not conform to the standard prescribed by the Association. The colleges must extend the time necessary for graduation to three full courses of lectures and require greater proficiency on the part of applicants for degrees, or find their faculties and graduates debarred from the privileges of the American Medical Association and all other associations affiliating therewith.

THE JOURNAL extends its heartiest co-operation to the earnest workers in this important field. We hope to see this term of study upheld by all the colleges.

There seems also to be a very prevalent sentiment against the regulations prescribed by railroads, and other corporations, for the

government of their surgeons. There is no more reason why a surgeon should do work for a railroad at greatly reduced prices than that a physician should engage to practice for wealthy, influential families at much lower fees than he charges the less favored. It is manifestly prejudicial to the interests of the profession and the public. We do not wish to be understood as casting any reflection upon railroad surgeons, for many of them are high-toned, honorable gentlemen who will readily acquiesce in the verdict of the profession.

The work in the various sections was of a high order and many valuable contributions to our general fund of information were made.

The social features were also very enjoyable, and few will there be who will not have pleasant recollections of the many elegant receptions, etc., tendered by the profession of Washington City.

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### MUCH NEEDED LEGISLATION.

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The laws regulating the practice of medicine in Georgia are sadly deficient in many particulars, and we hope the adjourned session of the legislature will amend them in several important respects.

There is the most urgent necessity for a State board of health and also a State licensing board. A bill ought to be introduced and passed providing for the establishment of both. There is no reason why such a bill might not be so framed as to treat all with perfect fairness. The public safety absolutely demands that something be done. The people are a ready prey to impostors and charlatans. Those who are in authority are in duty bound to protect the public from these pretenders, by putting in operation the necessary legal machinery.

We hope the bill now pending, requiring that all medical colleges shall demand that all applicants for graduation must have attended three full courses of lectures, will pass. Regulars, eclectics and homœopaths are agreed on that. Now, doctor, please, for the good of humanity as well as for that of our noble profession, appeal to your representatives and show them the necessity for such legislation and there will be no trouble about getting it. Something must be done to keep incompetent men from practicing upon the infirmities of the people.

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### DR. GASTON AND THE ELASTIC LIGATURE.

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At the recent meeting of the American Medical Association, in Washington City, Dr. Theo. A. McGraw, the Chairman of the section on surgery and anatomy, made an address upon the Elastic Ligature in the surgery of the intestines.

In the course of his remarks he referred to the original investigations of Dr. J. McF. Gaston, of this city, which appeared in this journal (1884).

We quote from Dr. McGraw's published paper (see *Journal of American Medical Association*, May 16):

"In 1884 Dr. J. McF. Gaston, of Atlanta, Ga., used it and other forms of ligatures in experiments on dogs which had for their purpose the establishment of a fistulous opening between the gall bladder and duodenum.

"I learned very recently from Professor Dr. Helfenrich, of Greifswald, that some experiments had been made by Dr. Franz Bardenheuer, at present an assistant in Professor von Bergmann's clinic in Berlin, which had for their object the production of intestinal anastomosis by the use of an elastic ligature, and through his great kindness have been enabled to secure a copy of Dr. Bardenheuer's paper from the author himself. . . . He,

evidently ignorant of Dr. Gaston's previous experiments, operated once successfully on a dog by the same method, for the production of an anastomosis between the gall bladder and duodenum. These experiments of Dr. Bardenheuer do not seem, thus far, to have borne any practical fruit. Without knowing of any previous experiments with the elastic ligature, I began myself to experiment with it during the early part of the summer of 1890, hoping in this way to find a means of accomplishing the desired end of producing an anastomosis with previous adhesion of the intestinal surfaces.

"I had not, until this time, been aware that Dr. Gaston, of Atlanta, had anticipated me in this kind of work, but learned of the fact from Dr. Senn. Dr. Gaston kindly sent me the papers, excepting the first, which he had published on this subject, beginning in September, 1884. Dr. Gaston endeavored to establish fistulæ between the gall-bladder and duodenum by the use of a ligature, sometimes of silk and sometimes of rubber. The main features of his method were the same as those of my own. The gall-bladder was fastened by Lembert sutures to the intestine, the ligature passed through both viscera and tied, and other Lembert sutures again above and around the ligature. Many of his operations were complicated by the ligation of either the hepatic, cystic or common gall ducts, and in all of them, as nearly as I can judge from the description given, the amount of tissue included in the ligatures was much less than in my own experiments. His very interesting experiments were the first of their kind, and he can undoubtedly claim the priority in the attempts to make channels of communication between hollow viscera by means of ligatures, although I cannot learn that he ever attempted to do so for any other purpose than to make a duodeno-cholecystotomy.

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DR. HOBART A. HARE, editor of the Philadelphia *Medical News*, has been elected Professor of Materia Medica and Therapeutics in the Jefferson Medical College, to succeed Dr. Roberts Bartholow. It is said that Dr. Hare will now resign his editorial duties.

DR. J. M. DACOSTA, who for twenty-seven years has been associated with the Jefferson Medical College, Philadelphia, has retired from the chair of Practice of Medicine.

A NEW era is dawning upon the history of medicine in the United States. Increased requirements have just been announced. Nine of the different States now require an attendance upon three complete courses of lectures and graduation, to entitle the candidate to practice medicine in their limits; and five of these are Southern States. All praise be to them! Other States are initiating measures for the accomplishment of the same end.—*Weekly Medical Review*.

It is proposed to open the medical department of the University of Texas in the autumn of this year. This department is to be at Galveston. The medical school will begin with nine professors and will give a three-years graded course of instruction of eight months each. Each of the professors will be paid, on an average, three thousand dollars per session. The Board of Regents will attempt to secure for the faculty comparatively young men, possessed of elements of success and capabilities of making a reputation for the institution.

The New York College of Physicians and Surgeons has been made a part of Columbia University. For many years the connection has existed practically in name only, but now the union is complete. The members of the medical faculty will draw their salary from the University fund. The University assumes entire financial control of the Medical College.

The Atlanta profession are much gratified to note the compliment which was paid their colleague, Dr. J. McF. Gaston, who was made Chairman of the Section on Surgery (for the session of 1892) at the recent meeting of the American Medical Association. Dr. Gaston presented a paper on Thoracic Surgery.

**CASE OF EXTRA-UTERINE PREGNANCY.**—J. W. Carhart, M. D. (*Texas Medical Journal*). In August, 1890, was called to see Mrs. V., 25 years of age, and on digital examination *per vaginam* found a tumor about as large as a hen's egg on the right side of the uterus, in the region of the right fallopian tube, some little lower than the tube, and seeming to involve the broad ligament. No fluctuation could be detected, no inflammation, but the lady complained of constant pain, extending at times down the right thigh. A distinct sulcus was clearly definable between the tumor and the fundus uteri, and the bladder appeared to be somewhat crowded, as she was troubled with frequent desire to micturate.

The battery was used with a light current, the negative pole in close proximity to the tumor, a glycerocotton tampon placed in the vagina, and tincture of iodine applied externally. This treatment was continued daily for over a month, and after making a careful examination was convinced that it was a case of tubal pregnancy. As the patient was thin in flesh, relaxed, and somewhat anæmic the outlines of the tumor could readily be made out. The following day, after thorough antiseptic precautions, an aspirating needle was introduced into the tumor through the vault of the vagina, and after penetrating to the depth of about three quarters of an inch, resistance was distinctly felt. Some blood was withdrawn with no amniotic fluid, and it was thought that the needle had struck a multilocular cyst, passing through one sac and striking the walls of another.

A few weeks after this the patient suffered considerable pain for several hours, followed by quite a hæmorrhage. The next day in consultation the diagnosis of tubal pregnancy was made. The depression between the tube and uterus, though distinct, was lessened from first examination and the fundus uteri had enlarged somewhat, probably from the presence of blood clots.

A Barnes' bag was introduced into the womb with a silk cover to control dilatation, and with a surgical pump dilated to its full capacity. No anæsthetic was used, as the patient did not complain of pain. The next morning at an early hour, being hastily summoned to the lady, found a loop of the prolapsed cord protruding some three or four inches. The tumor had lessened and become one with the fundus. The neck of the womb was shortened, the canal patulous, and by a little effort the feet could be detected. The foetus was delivered in a short time, followed quickly by the afterbirth, which was evidently in the tube and could be felt to contract, as the placenta passed out into the womb. This latter showed extensive fatty degeneration, but the foetus was well formed, five and a half inches in length and of four months gestation. Recovery was slow but uneventful.

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## Original Communications.

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### A PLEA FOR CONSERVATIVE MINOR GYNECOLOGY.

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BY R. R. KIME, M. D., ATLANTA, GA.

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[Continued.]

In all operative procedures the vitality of patient and the power to withstand shock and prevent infection should be considered. Has the patient sufficient vitality to carry on the reparative process after surgical procedure?

Has the patient sufficient physical and nerve force to withstand the shock of the operation? Can the operation be performed without infection? If these questions can be answered in the affirmative, operations of the greatest magnitude can be per-



formed with almost absolute certainty of success. The amount of cutting, scraping and separating is not so much a consideration as the environments of patient and the manner in which the work is done. Especially is this true in gynecology.

Take a patient with a blood dyscrasia, lowered vitality, nervous system a wreck, with septic influences present, then the most trivial operation is likely to prove disastrous, even the introduction of the sound so much condemned of late by some writers.

Because a urethral sound is introduced into the male urethra and carries the gonococci backward to new fields of infection with serious results, or unskillfully used makes a false passage, shall it be condemned and excluded from the armamentarium of the genito-urinary surgeon? Neither should the uterine sound be abandoned because it carries infection or perforates the uterus when improperly used.

If vaginal canal, cervix or sound be unclean, the instrument introduced and infection follows, is the much abused passive instrument to blame or the introducer?

With clean vaginal canal, cervix and sound, as well as hands of the operator, no trouble is likely to follow dexterous use of the sound. By reference to the writings of several prominent gynecologists we find all give the stereotyped rule of introducing sound guided by the finger without use of the speculum, some even condemning *use of speculum*. They fail to mention in that connection the necessity of disinfecting vaginal canal or cervix. In fact I have seen some of the most eminent men in New York so use the sound, urging the necessity of disinfecting finger and sound but not a word as to the dangers lurking in the genital passages of patient waiting to be conveyed to new fields of infection. Let us consider such a procedure, sanctioned by all authorities so far as I know.

Suppose patient requiring examination is suffering with some disease of vulva, vagina, cervix, even the endometrium, from any of which there may be an irritating discharge retained in the vagina, forming a very suitable nidus for the development of germs, especially in so fertile a soil and condition as the vagina

affords, through which introduce sound and what is likely to occur, especially if the endometrium be wounded.

Again suppose patient suffering with a specific vaginitis of a mild type or a severer form partially controlled by treatment in which the gonococci failed to gain entrance to that chamber where more important personages are developed, yet allowed the privilege of secreting itself between the rugæ of the vaginal mucosa, in the mucous membrane itself, or glands of Bartholini, there to propagate its species and renew its attacks, or even allowed the menial privilege so congenial to its nature of taking up its abode in some nook or cranny of the urethral canal evading a watery grave but not so securely located but that it may be dislodged by the examining finger and carried by the sound to the uterine cavity.

Even the ptomaines, the alkaloidal developments of the gonococci, to which add the heat, moisture, often the discharge of diseased conditions of vagina and adnexia, constitute a most active poison only awaiting the assistance of the unwary gynecologist to convey it to the uterine cavity to make its stately steppings felt. Another fruitful source of danger is the walking gonococci generator who, the night before the examination, playing the part of a lover, seeks pleasure in what should be sacred to the hymeneal altar and deposits not only the germs of a physiological process but of a diseased process as well, to wreak its vengeance on the unsuspecting female, or the husband who, recreant to his matrimonial vows, sought pleasure in forsaking virtue's paths and thus infects his innocent wife, to which the unwitting gynecologist acts the part of a conspirator and conveys the gonococci to the uterine cavity by the use of a *disinfected sound and finger*.

These are not fanciful pictures of dangers that never occur, but are true to nature and nature's laws violated.

Then, in view of these facts, shall the sound be used as directed in our text-books, often carrying germs and poisonous substances to the uterine cavity, producing serious lesions, perhaps death, when we have at command means to prevent such results? It should be a law inviolate never to introduce a uterine sound without first *disinfecting vaginal canal and cervix*, as well as

sound, and examining finger, at least rendering them aseptic—clean. I would advise the following rules for introducing sound.

1. Exclude acute active pelvic inflammation and pregnancy.
2. Disinfect, or render aseptic, hands, instruments, vagina, cervix, and uterine cavity if it contain any deleterious substances.
3. Use Sims' or bivalve speculum, exposing cervix. *If proper disinfection, may discard speculum.*
4. Hold sound between thumb and first or second finger, dipping uterine end into pure carbolic acid or tincture iodine; cleanse it with absorbent cotton and introduce without force. Thus used, there is no danger, and all information the sound need give can be obtained. The question might be asked, what is the legitimate use of the sound?

I would say, to measure cavity oftener, confirm diagnosis of tumors, position of uterus, condition of internal os and corporeal endometrium.

The expert may diagnose size and position of uterus, presence of tumors, etc., by touch; the non-expert needs the evidence of the sound to confirm his diagnosis. The expert can introduce sound by *tactus eruditus* without use of the speculum causing infection and trouble; the non-expert, using speculum, disinfecting, using sound by sight and touch, will not cause trouble if he remembers not to use force and that the sound is not a uterine repositior.

To meet objections to use of speculum, I would reply that where displacement of uterus is sufficient to be classed as pathological so that it can be usually detected by examining finger, that examining finger, in making a proper examination, is as likely to displace uterus as the use of the speculum; that the sound is more often needed where the uterus is not so easily displaced, when tumors are present, and more especially to measure depth of uterus, ascertain condition of internal os and corporeal endometrium, which can be as readily obtained through a bivalve or Sims' speculum, especially by the non-expert, and with far greater safety to patient.

To briefly continue the subject of minor operative work I would say, in all minor gynecological work, exclude pregnancy,

acute pelvic inflammations and pus accumulations, except where uterus contains putrid material, and give preparatory treatment; then, with aseptic operator, aseptic instruments and aseptic patient, little need be feared unless undue traction is made on uterine supports or adhesions from previous inflammatory deposits. Given a patient with lacerated cervix, lips everted, eroded, subinvolution, leucorrhœa, with reflex nervous manifestations, with consequent pelvic symptoms, prepare patient by constitutional and local treatment, operate.

If a young lady, generative organs not fully developed as a result of imperfect physical development, *severe pains during flow*, excessive nervous manifestations, weak, debilitated, and if not relieved by constitutional treatment, tonics, good food, out-door exercise, etc., dilate cervix, curette, introduce cervical drainage stem, keeping up use of stem for some time with judicious use of Faradic electricity. If she be married, such procedure will favor pregnancy, thereby often preventing a life of suffering. Certainly I do not claim this procedure will give relief where ovaries and tubes are at fault primarily.

If clinical history of case demonstrates dysmenorrhœa, deranged flow, "pain on passing sound through internal os, followed by slight hemorrhage, dilate, curette, drain, relieving patient."—(Wyle.)

If fungous degeneration of endometrium, "endometritis hyperplastica," metrorrhagia, with consequent weakening of vital forces not relieved by ordinary treatment, dilate, curette, drain.

In gonorrhœa the treatment should be active, energetic, certain. Properly dreaded by man, but should be far more so by woman. "Syphilis has slain its thousands; gonorrhœa its tens of thousands." It is only of late that the evil influences of gonorrhœa in the female are being recognized. The length of this paper forbids going into details, yet I would urge the necessity of destroying the gonococci, while yet in vaginal canal or urethra; failing of this, reach it in uterine cavity, if possible, by rapid dilatation of cervix, irrigation with mercuric chloride; then curette with dull curette to remove coating of albuminate of mercury and *dislodge and squeeze out* the burrowed gonococci, again

irrigate with mercuric chloride, then apply carbolic acid or tr. iodine, afterward filling uterine cavity loosely with a ribbon of iodoform gauze, end left protruding from cervix, by which to remove it at expiration of twenty-four or forty-eight hours, at the same time giving appropriate treatment for condition of vaginal canal. Repeat irrigations and applications to uterine cavity every one or two days until disease is under control, thus preventing in many cases salpingitis, ovaritis, and pelvic peritonitis with pus formation, demanding abdominal section menacing life of patient.

The results obtained by these minor gynecological procedures with those presented in former article (ATLANTA MEDICAL AND SURGICAL JOURNAL, June, 1891), certainly demonstrate a sufficient plea for the continuance of conservative minor gynecology.

Conservative, because they relieve suffering woman of many of the ills common to her sex, preventing many pelvic complications which render the patient a sufferer for life or a fit subject for the abdominal surgeon.

Conservative, because such procedures often save the life of a wife, a mother, the anchor to a happy home.

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## SYPHILITIC IRITIS.

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BY CHARLES DUNBAR ROY, A. B., M. D., ATLANTA, GA.

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Syphilis as a cause of iritis is very common. Noyes states that syphilis is the cause of thirty per cent. of all cases. Mooren, of Wiesbaden, states that out of 2,068 cases of iritis only 169 were purely syphilitic. This latter percentage is, I think, rather small in comparison to that of America. Statistics taken by me while house surgeon of the ophthalmic wards of Charity Hospital, New York, showed a percentage of 25. Of course the character of the cases must be taken into consideration, since they were those of the lowest order and who had possessed the worst hygienic

surroundings. Ratio of frequency of the disease between men and women was found to be 1.75 to 1, respectively. All cases occurred with syphilis in the secondary stage, the third stage being much the less common. Widder, in Graefe's Archives Ophth. vol. xxvii., p. 99, says that specific affections are local manifestations of the constitutional syphilis; iritis is very common in the second stage, occurs in the early phase of syphilis and is a product of the coadylomatous stage. Gummous iritis occurs in nineteen per cent. of all cases of iritis. The severer the syphilitic eruption is, the severer will be the eye symptoms.

In the pustular syphilide the iritis was always severe. Another distinctive feature of specific iritis is its decided plastic form. The products of its inflammation are very tenacious, and the agglutination of the iris to the lens capsule is very prone to occur. In every case this tendency to adhesion is one point which must always be borne in mind in its treatment. The frequency of syphilis as a cause of iritis compels the physician to inquire minutely into the history of every case which comes under his care. If the patient should have a rheumatic or malarial dyscrasia, the cases may prove much more tedious in their treatment. Especially is photophobia prone to persist in the weak and anæmic, for while the reaction of the pupil is normal, the general past hyperæmic state of the uveal tract causes the retina to be much more sensitive to light impressions. The objective and subjective symptoms of specific iritis will not furnish a perfect criterion by which to diagnose its special form, for they differ in no respect from other forms. If there is any one point which is especially significant of this form of iritis it is the excessive circumcorneal injection and the tendency for the exudation from the engorged vessels to raise the conjunctiva around the cornea into bleb-like elevations. The treatment of specific iritis must be prompt and energetic. Combined local and internal remedies are always necessary. Atropine must be pushed until some impression is made upon the iris. A solution of either 2 grains or 4 grains to the ounce may be used. Begin by instilling two drops of the solution into the affected eye every three hours, and if no impression is made upon the iris in twenty-four hours increase

the frequency to every hour, and even to every half hour, watching, however, for any toxic symptoms. As an adjuvant to the above there is nothing equal to hot water applied by dipping sheet lint into water as hot as can be borne, and allowing it to lie upon the eye until cool, to be again renewed. This is done for twenty minutes at a time, every two or three hours, depending upon the intensity of the pain. There is no anodyne equal to the above, and in relieving the congestion it is often more efficacious than the leeches. If the latter method does not succeed in ameliorating the symptoms, and great congestion still exists, two to three leeches are applied to the temple of the affected eye. In using this latter procedure the æsthetic tastes of the patient should not be disregarded. The internal treatment must be pushed to its full effect. Mercury in some form is always used, especially as this is nearly always the manifestation of the secondary stage. Inunctions may be used if the stomach is sensitive, but I prefer the following pill:

R. Hydrarg. Protoid., gr. v.  
 Ext. Hyoscyami, gr. vi.  
 Ferri et Quininæ cit., 3i.  
 M. Ft. capsules No. xxx.

Sig. One three times daily; increase until five are taken daily. This latter will be found very effective. The hypodermic method of administration now has many advocates but experience with it has not been sufficient to allow me to speak with authority. A daily observation of the patient by the physician is of great assistance to both, for though the directions may have been explicit, one often finds the omission of some important *sine qua non*.

14½ Whitehall St.

## TUBERCULOSIS.\*

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By R. W. STEWART, M. D., PITTSBURG.

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Tuberculosis may be truly said to be the pest of humanity. Few diseases are so insidious in their onset, and none so disastrous in their results. One-seventh of the human race is destroyed by it.

What tuberculosis is, the lesions it produces and the best means with which to combat it, will be my object to describe in this brief paper. Nine years ago Robert Koch proclaimed to the scientific world, and conclusively proved, that tuberculosis was the result of the growth in the tissues of a micro-organism called the bacillus of tubercle. So conclusive has been the proof of Koch's assertions, so thoroughly has all opposition been swept away, that it would be reprehensible on my part to needlessly occupy your time with a history of the discovery of the bacillus of tubercle, and the steady advancement of the views originally promulgated by Koch until all opposition was silenced and antagonism turned to enthusiastic support.

The manner in which the tubercle bacilli gain entrance to the system are various, the respiratory and alimentary tracts being the most common seats of entrance, but there is abundant testimony to prove that abrasions in the skin may afford a vulnerable point for the entrance of the bacilli, as is demonstrated in the production of lupus.

The bacilli may remain localized at the seat of entrance, or circulating in the blood current may fail to find a suitable location for their growth, and be ultimately destroyed or removed with the excretions. A less favorable termination, however, frequently takes place. The bacilli may find a nidus where the conditions are favorable for their growth in almost any of the tissues, but most frequently in the lungs, where they produce the disease called consumption; in the lymphatic glands, where

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\*Read before the Allegheny County Medical Society, May 19, 1891.



they produce the disease called scrofula, a term now rendered obsolete; in the skin, where it produces lupus; in the bones, where they are said to produce twenty-five per cent. of all chronic inflammatory diseases. The joint structures, the tendons and tendon sheaths, the peritoneum and the brain are frequently affected. In fact, but few of the tissues are exempt from their inroads.

In acute miliary tuberculosis almost all the organs of the body become simultaneously affected. This seldom or never occurs from a primary infection, but nearly always from the absorption of some caseous material from some pre-existing tubercular focus, by which a quantity of the bacilli or their spores are liberated in the blood and attack the tissues, whose vitality is already impaired, and hence rendered less resisting by the presence of a pre-existing disease. So varied are the manifestations and treatment of tuberculosis, according to the tissues affected, that it would be impossible in a paper of this character to do the subject justice. I have, therefore, chosen to confine my remarks as closely as possible to the condition known as pulmonary tuberculosis, because it is the one with which, as a body, we are most familiar and will, I hope, elicit a very free discussion. I will take it for granted that you are familiar with the histology and pathology of tubercle, subjects too well known to permit of discussion, and will pass at once to the consideration of the predisposing causes, the symptoms and treatment of pulmonary tuberculosis.

Prominent among the predisposing causes must be placed the hereditary tendency to the disease. It is not to be understood that the disease itself is inherited, but that the patient inherits from the parent pulmonary tissue, which has insufficient resisting power to repel the invasion of the bacilli. It may be well to remember that in a disease so prevalent as the one under consideration that the atmosphere, under favorable conditions, is frequently contaminated with the tubercle bacilli or their spores, chiefly as the result of the drying of tubercular sputa, and it must happen that every individual, or at least those living in communities where tuberculosis exists, is frequently exposed to

the contagium of the disease. If we also bear in remembrance that there is a standing declaration of war to the death between the bacilli and the tissues, and that in the conflict the weakest must succumb, we will readily realize why a parent with diseased lungs may bequeath to his posterity a legacy of tuberculosis. Another potent cause of pulmonary tuberculosis is prolonged contact with the contagium of the disease, as may be witnessed where the husband whose wife is tubercular contracts the disease, or *vice versa*; or in the melancholy but numerous instances where a member of a family without a tubercular ancestry contracts the disease, and the remaining members who have been in intimate contact with the patient are subsequently attacked.

Any condition or disease which lowers a patient's vitality is a predisposing cause of pulmonary tuberculosis, and it is the more powerful if the condition directly affects the respiratory apparatus. Among such may be mentioned imperfect development of the chest, occupations which hinder free and full respiratory movements, bronchitis, pleuritis and pneumonitis, the latter especially if the inflammatory exudate is slow in undergoing resolution.

It is unnecessary to pursue this part of the subject further, and I will only emphasize what my remarks must have indicated, that tuberculosis is a contagious disease, but in order that the contagium may thrive there must be conditions in the soil on which it is planted that are favorable to its growth.

When pulmonary tuberculosis has reached an advanced stage its manifestations are so plain, that he who runs may read; there is something so characteristic in the combination of symptoms that go to form the make up of such a case, that a diagnosis is already made before the patient has been examined. The emaciated figure, the stooped shoulders, the sunken chest, the rapid breathing, the hacking cough and the clubbed fingers are so unmistakable and so familiar that even the laity are seldom in error in their conclusions. But of such cases I have little to say; they have probably passed the point where we can aid them; their fate is already sealed, and the utmost we can do is to ward off a little longer the impending doom, and ease the rugged path-

way along which the victims of this cruel and relentless disease must tread, until death, less merciless, stills the hacking cough and in eternal sleep throws the mantle of oblivion over the scene.

Of much greater importance to us and to the patient is the diagnosis of the disease in the early stages, important because the earlier the disease is recognized the easier is it to be contended with, and the more beneficent is our therapeutics.

Of such importance do I consider the early diagnosis of phthisis that I feel constrained, in order to emphasize its importance, to digress from the subject, and speak a few words on the curability of phthisis. Consumption is usually regarded, by the laity, as invariably a fatal disease, and I fancy, also, by some of our professional brethren, especially that class not yet extinct, who have a contemptuous disregard for physical diagnosis and microscopical achievements. And they have good reasons for such judgment, since the disease is seldom recognized by them until it has reached a stage where its progress cannot be retarded, nor a fatal termination averted. That consumption is necessarily a fatal disease is a false and grievous conception, and the sooner it is totally eradicated the better will it be for the profession and humanity.

Consumption is often cured when in the incipient stage. This fact was early impressed on me by numerous illustrations which I witnessed a few years ago among the river men while under treatment in the marine wards of Mercy Hospital. These men are notoriously careless of their physical welfare, and their occupations are of such a nature that pulmonary complaints are rife among them. At the time I referred to I was anxious to familiarize myself with the early symptoms of phthisis, and made the routine habit of examining every marine's lungs, regardless of the disease for which he was admitted. I was astonished at the number of cases of incipient phthisis that were discovered, often among those who did not complain of any pulmonary trouble, or, at the most, of a slight cough. It was even more astonishing to witness the frequency with which the physical signs of incipient phthisis would disappear under improved hygienic conditions and appropriate treatment. It is only fair to add that in these cases

the diagnosis was based on the physical signs, as microscopical examination of the sputa was not made. Since that time I have witnessed a number of similar cases, although such a happy termination does not always take place.

I do not put before you my own limited experience as conclusive proof, but will bring forward the cold facts as gleaned from a source into which mistakes in diagnosis and results are not liable to creep, namely: *post mortem* examinations. The following is quoted from John Hughes Bennett's article on phthisis, in Reynold's System of Medicine (Vol. II., page 130): "The careful *post mortem* examinations now made with such regularity in our large hospitals have demonstrated the frequent occurrence of old condensations, cicatrices, and calcareous concretions at the apices of the lungs in persons of advanced age who have died of other diseases. In 1845 I pointed out that in the Royal Infirmary of Edinburgh they occurred in the proportion of from one-fourth to one-third of all the individuals who died after the age of forty. Roger and Boudet had previously shown that at the Salpetriere and Bicetre Hospitals in Paris, among individuals above the age of seventy, they occurred in one-half and in four-fifths of the cases respectively. There can be no doubt that these cicatrices and concretions indicate the healing and drying up of cavities and softened tubercular matter at some previous period in the life of the individual, and the consequent spontaneous cure of the disease in a considerable number of persons."

I return to the diagnosis of phthisis in its incipient stage, the importance of which I endeavored to impress upon you by pointing out that in this stage the disease, under proper hygienic and therapeutic treatment, was frequently curable.

Phthisis, in its incipient stage, is usually a very insidious disease. There is no line of demarcation to distinguish when health ended and disease began. Perhaps the very first indication is a condition of malaise—an indefinable feeling of not being well, without any concomitant symptoms to indicate pulmonary mischief. Often there is tenderness over one or both the apices of the lungs, or fleeting pains may attract the patient's attention

to this region. A slight cough, associated with but little expectoration, is a usual concomitant, although the cough may be severe and the expectoration profuse where a bronchitis has been an accompaniment or predisposing factor in the causation of the tuberculosis.

Another symptom of considerable significance is a slight elevation of temperature, which may not be over half a degree. If the temperature should be elevated on several successive examinations, and if there is no obvious cause for it, the presence of tuberculosis should be strongly suspected, and a careful examination of the lungs should be made. As regards the methods of examining the lungs a few words may be said. The patient should be stripped, only the slightest covering to the chest, such as light underclothing, is admissible. This rule should be rigorously observed, regardless of whether the patient be male or female, child or adult. If the patient, through false ideas of modesty, should object, it is the physician's duty to refuse to stake his reputation on a hazardous guess as to the condition of patient's lungs, whose sounds are muffled from his ear by the interposition of a pair of corsets, and the various other paraphernalia which deck the female form.

The physician who, under such circumstances, ventures to give an opinion as to the presence or absence of incipient phthisis, must either be gifted with an abnormal acuteness in hearing and discrimination in eliminating the extraneous sounds produced by the respiratory movements on the wearing apparel, or, what is more likely, he has a firm conviction that if he did hear the pulmonary sounds he would be unable to tell what they meant, and very considerably draws the line on his imposition at the point which necessitates the removal of the patient's garments.

To my mind the most characteristic of the physical signs of incipient phthisis is the broncho-vesicular breathing heard usually at the apex of the lung, and often best heard at the supraspinous fossa. The prolonged expiration heard in this region is significant, but care must be exercised that the blowing sound of the large air tubes be eliminated. With the broncho-vesicular breathing there is often associated a few crackling râles and a

jerking inspiration, although the latter may be present when disease is absent. Percussion dullness and increased vocal fremitus are of very great weight as corroborative evidence of tuberculosis; but the inability to detect either is of very little negative value.

Another very important element in the diagnosis is the microscopical examination of the sputa; and here we come to the only pathognomonic symptom of incipient phthisis, and that is the demonstration in the sputa of the tubercle bacilli. The negative value of the absence of the bacilli is of but little weight, except on repeated examination of the sputa.

I will pass over the methods of staining and examination for bacilli; also the symptoms of advanced pulmonary consolidation, and the destruction of lung tissue with formation of cavities, and hasten to the no less important subject of treatment.

Prominent among the remedial agencies must be placed improved hygienic surroundings, a generous diet, and suitable climatic changes. A climate which permits of out-door exercise the greatest number of days in the year is the one to which, in a general way, preference should be given. Where there is a tendency to hemorrhages an elevated climate should be avoided, but under other circumstances an elevated climate, such as Colorado affords, is preferable, inasmuch as the rarefaction of the atmosphere necessitates a fuller expansion of the lungs, which, probably, tends to the re-opening of the closed air cells. It may be well to sound a note of warning at this point on the folly of sending patients to another climate for the winter, in the hope that a permanent benefit will ensue. It seems to be a settled fact that patients who have been benefited by such a change are under the necessity of remaining in the advantageous climate, as their return, except for a limited period, is fraught with the danger of a renewed outbreak of the disease.

Among the therapeutic agents may be mentioned cod liver oil, which may be said to be of value only in those comparatively few cases where it does not nauseate. The hypophosphites are doubtless of value, as are a score of other remedies. A favorite treatment of mine, and one which was chiefly used in the cases

of the marines already mentioned, is the long continued use of the following prescription:

R. Hyd. chl. corr., . . . gr. j.  
 Ammon. chlorid., . . . ʒ ji.  
 Potas. iodidi., . . . ʒ jss.  
 Syr. pruni Virg., . . . ʒ iv.

M. Sig. One teaspoonful after meals and at bedtime.

The most remarkable remedy yet brought to light, and one which has made its already famous discoverer a household name in every home in the land, is Koch's lymph, or as it is more properly called, "tuberculin."

This remedy is the product of the tubercle bacilli. It is a brownish colored liquid, is exceedingly powerful, and is only used in the dilute form by hypodermatic injection, being inert if taken by the stomach. Now that the excitement following the announcement of the discovery has subsided and a considerable time has elapsed in which to test the value of the remedy, we may venture to give an opinion as to its merits and mode of action.

In order to understand the explanation given by Koch regarding the latter, it is necessary to speak a few words on the phenomena of coagulation necrosis, which is a peculiar change resembling coagulation caused by the action on the cells of a chemical product, or ptomaine, produced by bacterial agencies. It is supposed that the caseation of a tubercular nodule is a condition of coagulation necrosis produced by the action on the tubercle cells of a ptomaine, the result of the growth of the tubercle bacilli. Koch reasoned that if he could add to the already ptomaine poisoned tubercular tissue sufficient of the same poison he could produce at will a coagulation necrosis of the living tubercular tissue, and thus place it in a condition to be either thrown off from the surface or removed by absorption. That this is the correct theory of the action of tuberculin I do not venture to express an opinion, but it explains in a satisfactory manner some of the phenomena observed in its use, such as the curious fact that the tubercle bacilli are not killed by the use of tuberculin, and that only living tubercular tissue is affected.

It is exceedingly difficult to give a satisfactory opinion as to the value of a remedy like this which has so many biased opponents and blindly enthusiastic advocates. What I have to say is the result of considerable attention to the voluminous literature of the subject, as well as personal observation of a great many cases under treatment in the hospital of Berlin, and also about three months' experience with the use of the remedy in this city.

In order to be brief, my opinions must necessarily be dogmatical.

Tuberculin is of considerable value as a diagnostic agent but is not always reliable, the reaction being often wanting in the surgical forms of tuberculosis and also occasionally in the pulmonary form.

As a rule the most marked benefits are obtained where the necrotic tubercular tissue can be thrown off from the surface as in lupus, tubercular laryngitis and tubercular ulcers.

Most cases of pulmonary tuberculosis in the early stages will be benefited by the remedy, some to a very marked degree, so that a cure may be fairly claimed. Advanced cases of pulmonary tuberculosis where cavities have formed, and especially if the disease is rapid in its progress, are not likely to be benefited, and will probably be injured by the treatment.

In the surgical forms of tuberculosis, tuberculin will be an aid to the operative treatment by assisting in the complete eradication of the tubercular tissue.

The nature of this paper restricts it within narrow limits. Many points upon which I would like to touch must be passed unnoticed, but I hope that this fact may, of itself, stimulate among the members a friendly criticism of the paper and a free discussion of tuberculosis.



## CANCER OF THE RECTUM.\*

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 BY L. L. MCARTHUR, M. D., CHICAGO, ILL.
 

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In my brief experience as a surgeon it has been my fortune to number among my cases six examples of this disease in various stages of advancement, as follows : One, female, cancer within two inches of anus, colostomy and excision; one, female, cancer involving anus and lower rectum, colostomy, excision; one, female, cancer involving anus and rectum, colostomy, no excision; one, female, cancer high in rectum, no colostomy, curettage; one, male, Kraske's operation, colostomy (Dr. Fenger's case); one, male, no excision, curettage, no colostomy. With these there were no deaths as a result of the operations, though Kelsey states that the mortality for excision is thirty-three per cent.

Let me, before presenting the history of a case, call to your attention the following significant facts: In a careful inquiry—made by Cripps—into the family history of a large number of cases of cancer, the percentage of mortality by that disease was found almost identical with that of the general population by the same. In a very large proportion the disease is so situated that an infection could have been plausibly possible. Infection of husband from wife suffering from cancer of cervix has been in several instances well authenticated by competent observers. A much greater frequency exists near the sea than inland, and both Sheurlen, of Munich, and Thoma, of Heidelberg, have demonstrated the frequent presence of micro-organisms (psorosperms), which, in their opinion, have a specific relation to the causation of this disease.

In relative frequency of type, cylindrical-celled, flat-celled (epithelioma), and papillo-carcinoma stand in the order named. Allingham, who in 1886 had already reported thirty-nine cases of excision, is authority for the statement that rectal carcinoma

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\*Read before the Chicago Gynecological Society, January 16th, 1891.

usually runs its course in twenty-four months. He notes, however, cases ending in death in from four months to four years. His experience had been also (contrary to that usually noted) that the disease occurs more frequently in males than in females, and that its most usual site is within three inches of the anus. Cachexia appears at a very early period. The ages of greatest frequency range from forty-five to fifty-five, though it has been noted as early as the age of six. Cancer in this location frequently escapes the observation of the general practitioner, being mistaken for hemorrhoids; and, for this reason, too great care cannot be taken in the examination of middle-aged people in whom there are symptoms referable to the rectum.

*Treatment.*—James Adams urges that in every case there should be made a colostomy, saying: "In cases of any but the slightest degree the operation of removal may prove incomplete and the disease speedily return; . . . after complete extirpation of the lower end of the rectum the subsequent contraction is often very great, and even at times intractable, and in any case the healing of the wound will be much expedited and the chances of local recurrence diminished by diverting the course of the fecal matter."

Allingham justly condemns the making of a colostomy in every case of cancer of the rectum, stating that "often neither pain nor obstruction will ensue for months, or they may never occur and the patient may die from some other malady. Of course if a surgeon at once persuades all his patients who have malignant growths in their rectum to submit to colostomy under the promise that life will be prolonged or suffering averted, he will have many cases to report and very good but very valueless statistics."

There are four factors which make this operation justifiable: First, because the mortality of rectal excision can be immensely reduced by diverting the fecal matter from the site of the excision. Second, because there are in some of the cases excruciating pains, caused by the passage of fecal matters over the ulcerating carcinoma, which can be relieved by a colostomy, winning at the same time for the surgeon the gratitude of the patient.

Third, because in those cases in which the disease extends higher than the lower three inches, there is sure to be sooner or later a stenosis. This Jessop has demonstrated at the late meeting of the British Medical Association. He calls attention to the fact that where the disease is low down in the rectum complete obstruction seldom occurs, and that the opposite is true where the disease is high up. The reasons for this difference are to be found in the anatomy of the parts themselves; for while the rectum, as it approaches the outlet, becomes more closely applied to the sacrum and pelvic wall, in its superior portion it is comparatively free. Thus the contractile action of the colon is exerted with effect in forcing its contents through the contracted ring when that ring is fixed and immovable. But when the narrow portion is freely movable, as it is when situated in the upper portion of the rectum, the efforts of the bowel above succeed only in invaginating or otherwise displacing the growth, and fail altogether to effect any onward movement of the contents (Kelsey). Fourthly, it has been the experience of most operators that the cicatricial contraction which follows such an operation is often excessive and intractable, as in any of the inflammations, specific or simple, which so frequently result in a stenosis here. Allingham has found that if he would maintain the gut in a useful and patulous condition, it is necessary to have the patient wear a gutta-percha tube, which can be removed at will. Finally, an argument which needs no champion is the fact that thirty-three per cent. of all cases of carcinoma (as shown by the researches of Jessop in one hundred and two cases which were allowed to follow their course without any surgical interference) die from obstruction.

To sum up, I would urge that *prior to every excision in every painful case*, and in every case where the disease was situated *high up*, that a colostomy be made, the choice being in favor of the left inguinal. The method of excision recommended by the French surgeons has been that which I have utilized, preceding each excision, however, by a colostomy two or three weeks prior to the final operation. In this the main feature is a deep incision which exposes the posterior segment of the rectum from

the anus to the coccyx, when it is an easy matter to dissect out the rectal tube until one comes to the anterior portion. Here, if it is found that the disease involves one or more of the coats of the vaginal wall it is, in my opinion, best to remove a longitudinal segment of the entire thickness of the same, as it both renders the operation safer and more easily accomplished, and does not, as Kelsey would infer, greatly increase the danger. When the sphincters are involved a circular incision should surround the anal opening, and all be removed together. Dr. Guerin's suggestion that the gut be cut through by the ecraseur, modified by the passing through the normal gut of several threads for purposes of fixation of the proximal end after removal, as recommended by Verneuil; has been the procedure employed in the excisions I have made. The proximal end is then to be stitched to the posterior angle of the perineal incision or to the left side of the coccyx, and, after stitching up the vaginal wound in much the same way as after a posterior colporrhaphy or laceration, deep transverse perineal stitches render the making of a new and extensive perineal body very easy.

When the type of the disease is that of the cauliflower-like growth known as papillo-carcinoma, I believe the best practice is to remove it with the curette rapidly and well down to the base of the growth. The hemorrhage, very active and easily provoked while in the soft tissues of the tumor, is easily controlled when the base has been reached. In two such cases I have been successful in for a time relieving them of their distressing symptoms, but have not been able to follow their history for more than six months after operation.

The case I now report is of interest in showing the benefit to be derived from surgical interference.

CASE.—After having suffered with what she believed to be hemorrhage, the patient came to St. Luke's Hospital a year and a half ago, with symptoms of absolute stenosis of the intestine, and requiring immediate relief. The diagnosis of carcinomatous obstruction of the rectum being made, a colostomy in the left lumbar region was done, with relief to the urgent symptoms. After the lapse of three weeks, the artificial anus being well

established and healed, an incision of the rectum was practiced after the usual methods by a deep posterior incision from the anus to the left side of the coccyx well down the posterior wall of the rectum, which was then dissected laterally until the vaginal wall was reached, which was found to be involved to the level of the posterior lip of the cervix in the carcinomatous growth. The posterior wall of the vagina was removed, as well as the rectum, to this level, including the sphincter muscles. The rectum was stitched to the skin of the left side of the coccyx, and deep transverse stitches were inserted to make a new perineal body. There was speedy union and rapid convalescence. After the lapse of one year she returned to me with the artificial anus presenting a normal rectal mucous membrane normally attached to the integument to the left side of the tip of the coccyx, with the artificial anus almost closed from surgical interference by Dr. John E. Owens, but with a return in the perirectal tissue of the original trouble to such an extent that the line of cicatrix in the vaginal wall posteriorly and in the anterior rectal wall was again invaded by the new growth, which was beginning to cause painful defecation as at first. The patient, being much frightened with the symptoms of a return, came to me requesting a repetition of the operation. This at first I refused to make, telling her that I did not believe her longevity could be increased by such a procedure nor her condition materially improved. She then consulted Drs. Parkes and Fenger, both of whom, she stated, promised to operate upon her and offered her hopes of at least temporary relief. Coming back to me with this history and the threat that if I would not operate somebody else would, I had her admitted in the last week of September, 1890, to the Michael Reese Hospital, where I excised the portion of the rectum which had been drawn down and attached to the integument at a point on a level with the posterior lip of the cervix. I dissected out laterally, in so far as I could reach, all indurated tissue. I then found that it was impossible to bring the end of the rectum down to the integument, no matter how far I might extend my posterior incision, and decided that the best thing I could do would be to suture the end of the rectum at

the top of the vaginal incision after the cicatrix had been removed. I did this, then united the vaginal mucous membrane, much as is done for a laceration or operation for posterior colporrhaphy, and brought the lateral pelvic tissues together by very deep, heavy silk sutures, and, strangely enough, obtained a perfect union. The patient has, since the second week in November, been at home, is feeling well, has gained in weight, and has several times come to my office, each time stating that she feels better than she did during the year which elapsed after the first operation, that she now has control of the bowel and is capable of evacuating its contents without any artificial assistance—that is, without a douche, which I advised when she first left the hospital.

I believe this to be a unique case. I do not find, in what literature I possess, reference to a similar operation. I have no doubt that she will ultimately have a return of the trouble, because the cicatricial contraction which normally occurs with any inflammatory deposit about the rectum, whether from specific or simple inflammations, has already produced some suspicious induration.

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## ONE HUNDRED CONSECUTIVE CASES OF SKIN DISEASE.

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### VI.

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By M. B. HUTCHINS, M. D.,

Lecturer on Diseases of the Skin, Atlanta Medical College.

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### SYPHILIS.

It is necessary in making the diagnosis of syphilis to depend upon the appearances of the skin lesions and to have recourse to the history only as confirmative evidence, if a history of in-

fection is possible of attainment. Patients with syphilis frequently do not know they have it, or, knowing, think it their imperative duty to deny, and mislead the doctor if possible. Nearly every one of the cases to be described were diagnosed without regard for the "history," and the diagnosis, where positive, was fully confirmed by results of "specific" treatment together with, in some cases, confessions of the patient.

Of the one hundred cases of skin disease under description there were eight (or, including one with only subjective skin symptoms, of which the diagnosis was doubtful, nine) cases of syphilis. As the diagnostic points may be of general interest, I give the symptoms in detail in most of the cases.

First—lady, age forty-nine. There were groups of crusted, slightly infiltrated lesions on occiput and end of nose. Similar lesions on lips and fissures in each oral angle. Removal of crusts exposed raw, slightly bleeding and purulent ulcerative surface. The only "history" was of sore throat and rheumatic attacks in one leg a few months before. The husband was presumed (as circumstances indicated) to have had the disease, and to have infected this patient. (This information came out after the diagnosis was communicated.) For prudential reasons the patient received treatment at a famous resort for such cases, and is said to have returned free of the eruption.

Case two—female, age sixty. Gummatous, round, clear cut, silver quarter sized ulcer on lower leg.

Locally, used:

R. Ungt. Hg.,  $\text{ʒii}$ .

Ungt. O. Z.,  $\text{ʒvi}$ .

M. Sig.—Keep applied,

which aided in causing the ulcer to heal rapidly. Internally the ordinary mixed treatment was given. Probable infection from syphilitic grandchild.

Case three—female, age sixty-eight. Husband "died before the war." "Eruption" sixteen years, before the present time, and ulceration of the throat persisting for nearly a year.

When seen, there were present on nose and upper lip brownish crusts covering superficial ulceration, which secreted thin pus.

In naso-facial region small, crusted, discrete lesions with slight ulceration, and on left cheek an irregular, pigmented scar. From left shoulder to meso-dorsal region irregular, smooth scars, as after a burn, terminating below in a large plaque of grouped crusts, removal of which exposed superficial, clean-cut, roundish ulcerations. (The scarring above and ulceration below showed, quite typically, the progress of the serpiginous siphilitic ulceration.) A deep, pigmented scar, as large as the palm, situated near the tendon achillis, of right leg, marked the site of an ulcer which persisted for five years. "History," save of course of lesions, negative. Ungt. hydrarg. and zinc oxide, as for case two, was used locally, and "mixed treatment" (of which the following is an example) :

R. Hg. bichlor., gr. i.  
Potass. iodat., ʒi-ʒiii.  
Tinct. cinchon. c.,  
Tinct. gent. c., aa ʒii.

M. Sig.—ʒi in half glass of water after meals,  
was given internally.

Lesions had practically disappeared at end of a month, after which the patient was not seen.

Case four—male, age twenty-one. Chancre of cheek.\* Just in front of tragus of right ear was a circular, dome-like elevation the size of a silver quarter, summit crusted as the result of applications. Removal of crust showed appearance as if summit of lesion had been smoothly cut off, a circular erosion the size of a dime, granular, nutmeg looking, perforations filled with thin pus, the remainder of the erosion "raw" looking, and showing just a little moisture. There was a group of enlarged sub-maxillary lymphatics on corresponding side. Two weeks later the throat was very red, but returned to normal under use of simple alum solution, as gargle. The local treatment as used on the other cases for late syphilitic ulcerations was tried, as an experiment, on the chancre, but it remained, altogether, about six weeks.

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\*Reported before the Atlanta Society of Medicine.



Slight macular eruption occurred on abdomen and back about four weeks from first appearance of chancre. This eruption was most developed after being present two weeks, and its whole duration was about four weeks. General adenopathy was not present, only one enlarged lymphatic, in back of neck, being perceptible. The enlarged lymphatics were reduced upon the healing of the chancre. Rheumatism in left shoulder was the only other symptom, save, perhaps, occasional headache. Treatment was with simple tonics and remedies for constipation until the eruption appeared; then one-thirty-second of a grain of bichloride of mercury in a teaspoonful of compound tinctures of cinchona and gentian was given. Four months after occurrence of chancre there was a "mucous patch" beneath the tongue. Hydrarg. was doubled in dose and

R. Hg. bichlor., gr. i.  
Mucilag. Acac.,  
Aquae, aa ʒss,

was applied locally to the ulcer. Save one relapse of "mucous patches," which rapidly healed, the patient had no further trouble.

After the diagnosis was made, the patient told me that his working companion had a long-standing case of syphilis, with numerous mucous patches in the mouth. One day, in play, he tried to bite patient's ear, and thus probably inoculated a slight scratch where the initial lesion afterward occurred.

The next case was that of a young man of nineteen, previously under treatment for acne. There was a typical penile chancre, and the macular eruption on the lower part of abdomen and upper thighs. Was given pill of protoiodide of mercury, gr. 1-5, t. i. d. Epitrochlear and cervical glands were typically enlarged. After disappearance of the eruption he had no further trouble. The patient's acne rapidly disappeared just after treatment was begun for the new disease. It is still an open question whether the syphilis, the "specific treatment" or the acne treatment caused this rapid disappearance. However, the acne recurred later while patient neglected local treatment.

The next two cases were, and still are, uncertain, as the diagnosis, so far as made, in one was after an examination by lamp-light of a leg affected with a few ulcers and an iodoform eczema, and the other case was one in which symptoms of dermatalgia, and some scars, led a New York dermatologist to refer the patient back to me with the diagnosis of "probable syphilitic congestion of roots of spinal nerves." The treatment did not confirm diagnosis.

The next case shows the protean form of the disease in a marked degree. Female, age forty-two, referred for diagnosis. Between metacarpals, dorsal surface, of thumb and index finger an oblong infiltrated patch of purplish color, about the border of which were a few dime-sized, hard, roundish tubercles, with depressed and slightly scaly center. Color of patch removable under pressure. Small, oblong patch in similar situation on left hand corresponded to that on right. There was a group of waxy looking papular lesions on point of left shoulder, pea to small finger nail in size, surface thinly crusted (from scratching) and an oblong group of declining lesions (papules) back of left arm near border of axilla. The papules were from purplish, at beginning, to fawn color as they declined, and left stains of latter shade. When moist from perspiration the eruption itched, and scratching was followed by scaling and then crusts. Has had eleven children, all of whom died at the ages of from a few weeks to a few months, save the eighth, ninth and eleventh. The patient appeared in good general health.

The last of the series was a beautiful case for diagnosis. Patient male, age thirty-eight. Duration of disease three years, symptoms always as when this "history" was written. One large patch on left palm and smaller ones on palmar surface of, or between the fingers of, both hands, one or two tending to creep over on dorsal surface of fingers. The patch is thick, dry, scaly, and grayish in color, and tends to superficial fissuring. Close inspection shows this patch to be composed of separate, circular lesions the size of a half-dime. Disease has progressed towards ulnar edge of palm and undergone resolution on radial side. Whole eruption dry in character and belongs to the type

"papulo-squamous syphilide." The finger lesions are half-dime sized, dry and scaly, roundish, well-defined, when not confluent, and in rows or irregular lines, the whole process showing tendency to (and history proves) spreading in a serpiginous manner.

One lesion, on a finger, had the sometimes typical scaly collar. No "specific history" nor presence of other lesions.

Treatment. Rub away thickened epidermis, and

R. Emplastrum hydrarg.

M. Sig.—Apply in daytime.

R. Ungt. hydrarg.

M. Sig.—Apply, and wear gloves, at night.

R. Hg. bichlor., gr. i.

Kalii Iodat., ʒi.

T. Nucis Vom., ʒii.

Aquae ad. ʒiv.

M. Sig.—ʒi in half a glass of water after meals.

Patient returned to his home in another State and has not since reported.

Trichophytosis, etc., next article.

1½ Edgewood Avenue.

AMERICAN MEDICAL ASSOCIATION.—The session in Washington, D. C., May 5-8, was a decided success. Officers for 1891-2 are: President, Dr. H. O. Marcy, of Boston; Vice-Presidents, Drs. Willis P. King, of Missouri; Henry Palmer, of Wisconsin; W. E. B. Davis, of Birmingham, Ala.; W. E. Taylor, of San Francisco, Cal.; Treasurer, Dr. Richard J. Dunglison, of Philadelphia, Pa.; Secretary, Dr. Wm. B. Atkinson, of Philadelphia, Pa. Place of Meeting 1892, etc., Detroit, Mich., first Tuesday in June, 1892. Dr. H. O. Walker, Chairman of Local Committee of Arrangements. Among the many elegant receptions, that given by Dr. and Mrs. Wm. A. Hammand, in their palatial residence, "Belcourt," will long be held in special memory for its magnificence and hospitality.—*Va. Medical Monthly.*

## Society Reports.

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### ALLEGHENY COUNTY MEDICAL SOCIETY.

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SCIENTIFIC MEETING, MAY 19th, 1891.

C. S. SHAW, M. D., Vice-President, in the chair.

The topic for discussion, "Tuberculosis," was opened by Dr. R. W. Stewart. See page 265.

DR. T. C. CHRISTY : I think the paper of Dr. Stewart concisely and accurately written. His experience is of value to all of us. I agree with him on his points on the physical diagnosis of tuberculosis. I believe that every physician is in duty bound to strip his patient and examine thoroughly ; it is the only true way to examine a case. It seems to me that there is no better anti-bacillic material than pure blood ; that is, there is nothing that will destroy bacilli so much as pure blood. Secondly, that the larger cells that we find in the blood vessels will destroy the germs, and keeping these two points in view, we have a basis of treatment which cannot be surpassed. We must follow the line of Dr. Stewart's plan of treatment, that it is pure air, hygienic surroundings and care that are most efficacious in treating this disease. Now, going back to the idea that pure blood is the best germicide we have, anything that will induce the formation of pure blood will place these patients in their early years in a much safer condition than they would otherwise be ; that is, in public school buildings and in their daily exercise we can do much to prevent them from contracting disease. Another point which has been lately advanced by a French writer: He says that animals are more easily affected by bacillic injections where they have been deprived of food ; or, in other words, that hunger will make persons more liable to contract this disease. Tak-

ing pigeons, which are not particularly susceptible to bacillic influence when deprived of food for several days, injections of the bacilli caused inoculation and death, whereas, where they were well fed, they were free from the influence of the bacilli. I think if we are careful in the examination of patients, careful in the management of their case not to underfeed them and to look after their hygienic surroundings, we accomplish more than we can in any other direction.

DR. GRUBE: One person in seven dies of tuberculosiis, and I venture to say that one-half of the race have the germs of tuberculosis in their system. It is natural that a disease of such importance should command our careful attention. Our profession is exceedingly active in devising some means for the treatment of this disease. I think the greatest point, however, one which the speaker who has just preceded me brought up, is the early diagnosis and treatment of this disease. It is a disease of predisposition, and I believe that the ground work is laid in the embryo. I think here is the secret of the predisposition to tuberculosis. Dr. Trudeau, of New York, made some valuable experiments. He made an experiment with which doubtless many of you are familiar, and which will, I believe, become classic. He took fifteen rabbits and divided them into three lots. With the first five, he injected the pure solution of bacilli into their lungs, into the abdominal cavity, and under the skin of the neck. These five he placed in a dark cellar. The next five were inoculated in a like manner, and were turned loose in an island on the lake in the month of June, and they were fed with vegetables in addition to the vegetation upon the island which was accessible. The other five were not inoculated at all, but a hole was dug in the middle of a field; this hole was ten feet in depth and the remaining five rabbits, having been placed in the box, were lowered to the bottom of the pit. The box was covered with boards and dirt, a trap hole being left for the introduction of food. Of the first five rabbits, in the cellar, four died within a month, and all of general tubercular infection. This existed not only in the lungs but generally. The five in the pit were taken out perfectly well; they were emaciated, their coats were rough, but there were no

signs of tuberculosis in any of them. Of the five which were liberated on the island, one died within a month; it had some tubercular affection of the lungs. The other four grew fat, and at the end of four months, were perfectly well and in fine condition; they were killed then, and not even the point of inoculation could be found; there was no sign of tuberculosis whatever. Now I think this is a lesson which can be made of practical use. Some one has said that the cause of consumption in London was that the poor were too poor to buy butter and fat, and the rich injured their digestion with too much pastry. What I want to bring out is the point that the rapid loss of weight in one who has the predisposition ought at once to call our attention to the fact that he is preparing the way for bacilli, and it is an open question whether in such cases the loss of weight is caused by bacilli or whether the ground is merely being prepared for them; I am inclined to believe that the latter is the case. Of course with a great many patients it is impossible to do very much. It is a matter of ability to bring the patient through the early stages of the disease safely. This means giving up a vocation which they cannot afford to give up. The question of occupation is one of the principal ones in this disease. Nearly one-half the printers die of consumption.

**DR. BUCHANAN:** Dr. Grube's remarks call to my mind the theory proposed by that excellent pathologist, Dr. Formad, to the effect that tubercular individuals were such as had narrow lymph spaces, that it was the obstruction in the lymph spaces that caused tuberculosis, and he endeavored to prove this by microscopical measurements of the lymph spaces in different species of animals. I believe he made the same observations on human beings who were tuberculous, although I am not sure of that. I do not know whether Dr. Formad has endeavored to reconcile his theories with the modern views of tuberculosis as brought forward by Koch, but I believe that Dr. Formad's theory had its origin about the time that Prof. Koch discovered the bacilli of tuberculosis.

**DR. BANE:** I have been in Colorado several weeks, and there met many people who had gone to that State on account of con-

sumption, who went there expecting to die, but whose lives have been spared by reason of the climate, or you might say, by the air, which is dry and light, especially when you go where it is so high as it is at Colorado Springs and Denver. As has been brought out by Dr. Stewart, in order to get sufficient oxygen more air is inhaled, the lungs are expanded and the cells which are not used in this district are employed there, and there is no doubt this is one of the reasons why those patients who have not a sufficient breathing space are so much better in that climate. It is a fact that many persons die in Colorado of consumption, but unfortunately they go there too late to be benefited; if they would go while in the incipient stages, certainly many of them would live to a good old age, but as a last resort many go there when they should stay at home, when they would live longer at home surrounded by home influences, than they do in the climate of Colorado, with all its advantages. There are many things to be said about sending a patient to Colorado. Persons suffering from heart disease fare badly in the climate on account of the rarity of the atmosphere; persons of nervous temperament do not rest well there. I met there a friend, a neighbor of mine in the profession, who some six years ago went to Colorado Springs. He was told that it was not worth his while to go, that he would not live more than six months. However, he went, and began to improve from the time he reached Colorado. When he arrived there, his temperature dropped down to normal and there remained. He continued to cough for eighteen months. Then he thought he might come home to Philadelphia; he returned home, and after remaining some two weeks, his cough returned and he was obliged to once more go to Colorado, and on his reaching that place the second time it took him as long as before to become free from the cough and feel well again. He then learned he would have to remain in Colorado if he wished to live long. From Colorado Springs he went to Denver, where he has a good practice and good health. From his appearance I should think he weighs about 200 pounds. One physician who went there with consumption now weighs 300 pounds. Certainly we have patients here that we cannot expect to cure in this climate

that we are not justified in keeping here if they have the means to take them to a climate such as exists in Colorado. This is the impression made upon me after visiting the State and meeting these people. True, they have to remain there, but it is no punishment to live in Colorado, where they have as fine a climate as I have ever seen, and where eastern people, with eastern business and social ideas, form the bulk of the population.

DR. RIGG: I was much pleased with Dr. Stewart's paper. I think it deserves our careful consideration, and there are many points in it that would bear further investigation. The doctor's calling attention to early diagnosis is a very important thing, also, the natural tendency or the inherited condition. The doctor stated that tuberculosis is not an inherited disease, which fact is well established at this time. The predisposition, however, is inherited. We have it in the animal as well as in the human family. You take the rabbit and the Guinea pig, they are naturally tuberculous; the dog and cat are naturally non-tuberculous; the rat is not naturally tuberculous. Now, you take a family of children coming into the school-room, and it is a comparatively easy matter to see which are tuberculous children. The conditions under which they have been reared may have had much to do with developing the condition. I am not sure that nationality has not something to do with it. Six or seven years ago, I made some little investigation on that line. This investigation of mine was conducted through the southern part of Westmoreland county, and the northern part of Fayette, and covered a period of three years. I suppose in all I collected statistics from 150 different families. In regard to the investigation of Dr. Formad, it was my pleasure to be with him a part of the time he was making the investigation. He took the children in the hospital and held *post-mortems* there and examined some of the tissue from all children who were believed to be tuberculous yet had sickened and died of acute diseases, and also from children who had died of tuberculosis. He examined the connective tissue from other children that had died that we believed to be non-tuberculous, and there was a marked change, a marked differ-



ence in the lymph channels that fully convinced me that there was more in it than mere theory.

My recollection is that he had modified his views at that time greatly with reference to the cause of the bacilli. He admitted that the bacilli might be the carrier of tuberculosis, and that it might possibly be the specific poison.

The question not settled in my mind is this: are the bacilli, as a rule, one of the early evidences of tuberculosis? Take a subject that is predisposed to it, that has, if you please, the narrow lymph channels, and will you not have a certain amount of engorgement in the lungs before the bacilli? In other words, are the bacilli present before there is inflammation, or are the bacilli formed subsequently to the inflammation? In regard to the influence of surroundings that has been referred to by both the gentlemen who have spoken. An experiment was made on rats; I do not recall the particular poison that was used, but it made an impression on my mind. A number of rats were caught and kept under favorable conditions; they were injected with specific poison and turned loose in comfortable circumstances under hygienic surroundings. Others were put in a treadmill, where they were obliged to work and kept at it until they were tired. They sickened and died with tuberculous disease. The first lot lived and thrived. But that is only one evidence of many that pure air, pure food and pure surroundings fortify the system against the attack of any disease; I do not care whether it is tuberculosis or something else; if there is a special tendency to tuberculosis, it will likely be that; if there is a tendency to something else, it will likely be that. In regard to the influence of a rarefied atmosphere; I think there is a good deal in that, and we might see why, if we bear in mind the fact, that the apex of the lungs is the portion usually involved first. It is, perhaps, the portion of the lung least used under ordinary circumstances; expansion is less there than at any other portion of the lung.

I have nothing to say as to treatment. In regard to the tuberculin, it seems to me that the theory on which it is given will hardly bear us out in using it constantly. I think it a step in the right direction, yet the question that comes up in my mind is

whether or not you can generate a poison from the bacilli that will do what is claimed for the lymph, or that will aid nature in throwing off the diseased tissue. It seems to me we cannot expect much on that theory. As far as I am personally concerned, I want to see some more rational theory advanced or else more satisfactory experience. I have two cases on hand now, and for a month I have debated in my mind whether or not to advise a trial, and I have not had the courage to do it. The patients are willing and ready to take the risks if so advised, and if there can be anything that will help me to decide, I would be very glad. One of them is a case of tubercular trouble, pulmonary tuberculosis, and the other is a case which Dr. Buchanan saw with me six weeks ago, tuberculosis of the lymphatic glands and the ankle joint.

DR. STEWART: As to the doctor's remarks in regard to Colorado. A patient came to my office from Colorado recently; he had returned to this city and gone to work. I examined his lungs and found marked consolidation of the upper portion of both lungs. I told him to go back to Denver as soon as he could. I do not think I could have done him any good. With regard to Dr. Rigg's question as to whether the bacilli are present at the early stage, my understanding is that the presence of the bacilli is an essential factor at the initial stage of the disease, and that the tubercular products are the result of the growth of the bacilli.

I would speak a few words of my own results in the use of Koch's lymph. The first case was for diagnostic purposes on a patient in the Mercy Hospital, but he left before a result could be ascertained. The second and third cases were in St. Francis Hospital; both cases were confined to their rooms and the disease was progressing rapidly; both improved at once and have since left the hospital, although still continuing under treatment, and their improvement still continues. The remaining cases were treated in Mercy Hospital; one advanced consumptive did not improve and has since died. Another remained two weeks in the hospital with but slight improvement, but continues the treatment at his home, and is steadily improving. A case of

destruction of the nose supposed to be lupus, did not give any reaction even to a dose of twenty-six milligrammes, and was not benefited. I considered the condition as that of an epithelioma. A case of lupus of eyelid at present under treatment gives promise of a cure.

#### HEMORRHAGE AFTER LITHOTOMY.

DR. J. W. MACFARLANE: On the 15th of last April, assisted by Dr. Small and the residents of the Western Pennsylvania Hospital, I did a left lateral lithotomy upon Jas. Mehen, removing a mulberry calculus weighing six drachms.

The history of the case is as follows: The lad is sixteen years of age and undersized. His trouble dates back to last July, when he moved to, and secured employment in, Kittanning. The pain and vesical irritation that began to bother him soon after his advent in the place he attributed to the drinking water, which, he thought, did not agree with him.

In spite of some treatment, his symptoms steadily grew worse during the fall and winter months, when he finally presented himself to Dr. Thos. McCann, who sounded him and discovered a stone in the bladder. He was sent to the West Penn Hospital, and I operated upon him as before stated.

No trouble was experienced at the time of the operation; there was some bleeding, but no more than is usually seen; the stone was extracted slowly, and the bladder carefully washed out. I saw the patient about half an hour after the operation, and, though I did not examine the bed, I felt the boy's pulse, and left him thinking all was well. About fifteen minutes after this the nurse noticed that he was bleeding freely. Dr. C. B. King, who happened to be at hand, introduced an umbrella-shaped tent into the wound, a catheter forming the center of the tent, and oil silk the outer, the space between the silk and the catheter being packed with cotton. This seemed to arrest the hemorrhage for a time, but the presence of the catheter and clots in the bladder produced irritation, constant straining, with expulsion of the tent, and a return of the hemorrhage.

Between three and four o'clock, some three hours after the

operation, Dr King having gone home, I was summoned to the hospital, and on my arrival found my patient with head down and feet elevated; he was pale, sweating, vomiting, thirsty, with a rapid pulse, and in anything but a promising condition. I examined the wound, but was unable to find the source of hemorrhage. I removed some clots from the bladder, tried to introduce a fresh tent, but the attempt at introduction produced so much straining that I immediately abandoned it.

I then slipped a piece of gauze, well oiled, over my index finger, introduced it into the wound, and, withdrawing the finger, packed the space as well as possible with absorbent cotton; but this did not appear to arrest the hemorrhage, the oozing still continuing. The irritation of the bladder being so great as to preclude the introduction of anything within its walls, we concluded to flush the intestines with hot water, and see what effect that would have.

A flexible rectal tube was introduced well up to the sigmoid flexure of the colon, and a large quantity of hot water forced into the bowel. The rectal tube was withdrawn, a pad placed over the rectum and tent (which had been held in position) with a T bandage over all. I am happy to say that the effects of the hot water were soon made apparent, the pulse improved, and the hemorrhage was arrested.

At eight o'clock that night the patient had reacted; there being odor of urine in the bed, the pads were not removed until the following morning, when they were discontinued. Dr. Todd, the resident in charge, kindly sat up with the boy the first night, giving him hypodermic injections of whisky or aromatic spirits of ammonia when required.

The patient, though weak for a time, made an uninterrupted recovery from this on, being absolutely free from pain. On the 28th of April he passed water through his urethra. On the 29th he passed a minute fragment of stone, evidently one of the small points which you will see is missing in the specimen.

The boy was discharged from the hospital perfectly well on the 15th of May, one month after the operation.

It is probable that the vessel from which the bleeding came

was injured during the extraction of the stone, which is studded with sharp points, as you see, and that it gave way at the time or a short time after the patient was lifted into bed.

DR. BUCHANAN: It was my fortune six years ago to assist Dr. Kersey in a similar case. At St. Francis Hospital he removed a very large stone through an incision which was probably of necessity insufficient. At all events, there was a great deal of trouble in removing the stone, and, although there was no hemorrhage at the time, there must have been considerable contusion of the tissues. If I recollect aright on the sixth day a very severe hemorrhage came on. Dr. Kersey was sent for late in the afternoon, and I went with him to assist in checking the bleeding. We tried all the ordinary means to stop the hemorrhage, endeavoring first, of course, to secure the bleeding vessel. The man seemed to be at the point of death, and we were not long in trying the umbrella catheter; but in this instance, at least, it was a dismal failure. A sufficient pressure could not be exerted. We then passed a catheter of considerable calibre as far as the bladder, and put two or three sponge-tents along-side of it. The bleeding was instantly checked, and the man recovered.

DR. STEWART: I have had two cases—one hemorrhage from rupture of the urethra; there had been several attacks of hemorrhage, the patient becoming very faint. When I saw him he was bleeding, and there was an opening in the perineum, which had been made to relieve the extravasation. The hemorrhage was checked by plugging around a silver catheter placed in the perineal opening. The second case was similar to the first, except that the hemorrhage was caused by ulceration from prolonged pressure of a silver catheter against the margins of an exploratory perineal opening. The hemorrhage was checked in similar manner to the preceding case.

GYNECOLOGICAL AND OBSTETRICAL SOCIETY  
OF BALTIMORE.

## APRIL MEETING.

The President, DR. HENRY M. WILSON, in the chair.

DR. WM. P. CHUNN related a case of ascites, which he treated by tapping and permanent drainage with apparently good results.

DR. B. B. BROWNE operated more than a year ago upon a woman with ascites, who also had an abdominal tumor, which proved to be papillomatous. There has been no return of either the dropsy or the papillomatous growth. He referred to the many cases of laparotomy and washing out the abdominal cavity.

DR. GEO. W. MILTENBERGER could not see why any malignant tumor should not be able by irritation of the serous membrane to cause ascites. We often see ascites without any definable cause, and when a growth did exist it seemed a very good reason for the presence of the fluid. He referred to the case of a colored woman operated upon by Dr. Neale.

DR. L. E. NEALE said that in the case of the colored woman referred to there was no assignable cause for the ascites, except the presence of a sub-serous uterine myoma; at the operation he removed the uterine appendages. The growth remained but there was no return of the ascites. There was also a complete procedure, but after the operation he was enabled to keep the uterus in place with a soft rubber ring.

The tumor gradually diminished and ultimately disappeared.

Is the exposure and irritation of the serous membrane during the operation a sufficient explanation of such an alteration in its function when the apparent cause of the ascites remains?

He thought the question eminently important and practical in its bearing and that it required further elucidation.

DR. WILMER BRINTON remarked that in a case of cirrhosis of the liver in a male patient, tapping for the ascites had been

followed by a permanent opening which persisted until the patient's death, one month afterwards.

DR. J. WHITRIDGE WILLIAMS, in referring to Dr. Moseby's remarks, said that the ascites accompanying papillomatous growths was considered to be due, in a great part, to direct exudation from the vessels of the growth; he also referred to tubercular peritonitis.

DR. B. B. BROWNE exhibited a small tumor, about the size of a large hickory nut, and apparently a fibroid, which he had removed from a point a little to one side of the median line and between the clitoris and urethra. It pressed on the urethra, interfering with micturition. The growth was easily shelled out and the patient did perfectly well. It was the first growth of the sort he had seen in that locality.

DR. NEALE related a case of imperforate rectum in a white male child, naturally born at full term, of healthy parents. The child was puny, weighing only  $5\frac{3}{4}$  pounds at birth, and one inch within the anus the rectum was imperforate. Dr. T. Harvey operated upon the child when it was two and a half days old, very feeble and partly cyanosed. No anæsthetic was used. Anus was cut through, the perineal structures laid open, the coccyx removed, the rectum opened through its posterior wall just above the imperforate part, and its mucous membrane stitched to the skin just behind the original aperture. The stitches sloughed out and the large wound healed slowly by granulation. A copious discharge of flatus and meconium occurred during the operation and the tympanitic abdomen disappeared.

Profound shock and collapse followed the operation, the child lying motionless, the feet and lower limbs cyanosed, the face and head less so; jaw dropped, mouth opened, eyes closed, lids blue; surface temperature but little if at all lowered. No cry. The features were frequently pinched or wrinkled from pain, becoming more or less blue at irregular intervals.

In this condition the child would make no effort at suction, but would swallow two teaspoonfuls at a time of milk and brandy when poured into its mouth, rarely refusing to swallow and

never vomiting the food and stimulants, which were given freely and frequently.

For nearly two days and a half did it remain in this state, partially rousing during the administration of food, or other disturbance, and again relapsing. Even after this period, when the first decided improvement occurred, the child would frequently relapse and remain in this condition for hours at a time. The first two weeks of its life were passed in this manner. The digestive and urinary apparatus functioned normally.

From the tenth to the fourteenth day these attacks gradually diminished, and ultimately disappeared.

The child is now nearly two months old, but very feeble and weighs only  $5\frac{1}{4}$  pounds. It has been reared chiefly on condensed milk. The dense cicatrix just about the seat of the old imperforation has to be dilated daily with the finger. Another operation will be necessary. No diagnosis of abnormality in vascular system could be made.

DR. BRINTON mentioned a case of a child which lived nine or ten days with an open ductus arteriosus.

DR. MILTENBERGER said that in Dr. Neale's case the sphincter and anus were perfect.

He thought that no ordinary trouble could account for the symptoms in the case. The cyanosis would not clear up entirely and then recur. He did not consider the condition one of collapse. There was no feebleness of pulse or coldness of surface. The child would lie in an apparently comatose condition, with no evidence of sensation, and then recover. The first attack followed immediately the operation and was evidently from shock; but after two or three days it could not be attributed to this cause. There was no chill or febrile condition.

After the child had commenced taking food he used quinine by inunction and also small doses of dialyzed iron, and, as he believes, with benefit from the latter.

He was inclined to account for the condition in this way: A very feeble child had food forced upon it for eight or ten hours, and when it had taken in all it could, it apparently fell



into a condition similar to that of hybernating animals, and when the supply of food was exhausted, it would recover and take more nourishment. This condition entirely disappeared after the first two weeks.

W. S. GARDNER, M. D., Secretary.

712 N. Howard St.

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## TRANSACTIONS OF THE GYNECOLOGICAL SOCIETY OF CHICAGO.

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REGULAR MEETING, JANUARY 16, 1891.

DR. W. W. JAGGARD, President, in the chair.

DR. L. L. McARTHUR read a paper on

### CANCER OF THE RECTUM.\*

DR. C. T. PARKES: The case as presented by Dr. McArthur is very interesting to me, and I think he is to be complimented on the skillful attention he has given to this patient and the success which has resulted from his interference. It seems to me we must look upon this operation for the relief of this terrible disease mainly as a palliative treatment; it is seldom curative. Certainly it removes the manifestations of the disease for a time, and, above all, is desirable, as Dr. McArthur has said, from the fact that it relieves the patient from the local distress caused by the disease, especially from pain, which is present in all these cases, and the symptoms of on-coming obstruction which accompany the later stages. My experience with it has been rather moderate; as I recall the cases I have met, and have thought a little about them since receiving the notice of this meeting, there come to mind *nine* cases in which operation has been done for excision of the rectum, two cases in which simple incision was done, and two cases which are interesting from the fact that they accompanied the presence of ovarian tumors, and one case which was

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\*See page 274.

situated very high in the rectum and no interference was practiced—in all fourteen. Of the nine cases in which excision was done, five were operated upon according to the plan of Kraske; in the others success was attained in the removal of the manifestations of the disease by merely external incision of the soft parts, without interference with the sacrum or coccyx.

Of these cases, which represent a period of work of eight or ten years, some are living to-day, but most of them are dead. None of the cases of excision were preceded by an opening into the colon. I think the statistics which the doctor gives as to the mortality of the disease, as the result of immediate excision, is based upon the results of pre-antiseptic days rather than the present. I am not one of those who believe that the contact of fecal matter with the wound is at all times hurtful, as I have had in my experience many cases in which wounds have been bathed in fecal matter without any septic condition following.

I can see readily enough that the previous operation for an artificial anus can be a benefit to these cases, and will likely predispose to the earlier and more rapid healing of the rectal wound, simply because it prevents the fecal material from passing over the raw surface. The operation of forming an artificial anus in itself is of little consequence, and should be, as a rule, attended with little fatality. That it is a necessary procedure I am not inclined to believe; neither do I think that it makes very much difference in the mortality. As far as the relief given in preventing the discharge from coming over the wound is concerned, I have to agree with Dr. McArthur's statements.

The disposition is, in all these cases, to a comparatively rapid return of the disease. We must always remember, in the treatment of cancer here, as well as elsewhere, that the operation itself may stimulate or produce infection. In two cases in which the operation was done by myself, there followed no local manifestations of return of the disease, but, within eighteen months their appeared to be general infection of the entire body, as shown by evidence of disease in the liver and in the lung, and

the presence of cancerous nodules of different sizes in the integument.

There is no question but that every one of these patients will be grateful to the surgeon for the removal of the manifestations of this disease; but, as I said before, we must look at it in the true light and tell these patients that the relief is only temporary and cannot often be curative where the disease is really cancerous in its nature. Again we must bear in mind that quite a number of surgeons of great experience, men who have seen this disease in all its conditions and ravages—believe that the establishment of an artificial anus itself is a sufficient relief to the case. Dr. Thomas Bryant, of London, is not an advocate of excision, but is an advocate of an artificial anus and relieving the patient entirely of the necessity of using the diseased portion of the bowel for the transmission of fecal matter, and thereby allaying inflammation.

Again, we must remember that other operations are done besides excision of the rectum, which is a formidable operation and leaves disgusting results in many cases. Some other operations have been done which surgeons of experience believe to be efficacious; these are local in character—that is, the complete division of the mass backward toward the sacrum, in that way providing for the easy exit of the fecal matter. Of course the era of operative procedure is upon us, and particularly is this operation advocated by European surgeons, and also very largely by American surgeons; but I think if all the cases were examined as carefully as those cases have been which Dr. McArthur has presented to us to-night, and discussed as coolly and calmly as he has discussed them, none of us would be very much in favor of promising a great deal for the operation.

DR. HENRY T. BYFORD: I would like to emphasize what Dr. Parkes has said, that this is a palliative operation and not justifiable when it is immediately very dangerous to the life of the patient. The case related was very interesting to me, because it is similar to a case which I have treated, and which illustrates the principle which should be carried out in treating cancer of the rectum in women. In this case the sphincter was not

involved, although the rectum from about two and a half above down nearly to the sphincter was affected on its anterior and lateral aspect. I removed portions of the lateral and anterior rectal walls, and the posterior vaginal wall. Instead of drawing the parts together in front of the rectum, I operated upon the principle that all raw tissue not covered by mucous membrane will contract and obliterate the entire tract within it; so I endeavored to secure as large a surface of mucous membrane for the canal as possible by leaving the vagina open and merely closing up the vaginal entrance. There is another reason for removing, in cancer of the rectum, all of the rectum that we can, viz., that a return of the disease in connective tissue is not as painful as when it attacks the viscera. In this case the patient was able to evacuate the bowels until the entire pelvis was filled up with a mass of carcinomatous tissue, without very much pain. She died finally of exhaustion more than anything else. The point in all these cases is to get as much mucous membrane as possible, using the vagina the same as in any other operation.

DR. L. L. McARTHUR, in closing the discussion, said: In presenting the patient this evening I did not do so to advocate such an operation, although it does seem to me that, in cases in the female in which carcinoma occurs low down in the rectum, in reality it would be a procedure more advisable than to make an artificial anus at one side of the tip of the coccyx, because of the statement of the patient that she knew when the bowels desired to move. She had a peculiar feeling, she says, and has the power to expel the contents, thus escaping the exceedingly distressing symptoms of involuntary discharges, which always occur with an artificial anus at other points. In regard to the statistics which I quoted as collected by Kelsey, in the article which he wrote on this subject for the "Reference Hand-book of Medical Sciences," published in 1886, he stated that the mortality from the operation of excision was thirty-three per cent. In Sajous' *Annual* for 1890, there is a collection of statistics after Kraske's operation, and the mortality is stated at fifty per cent. Kelsey happens also to be a contributor to this department of Sajous' *Annual*, so the mortality has rather in-

creased than decreased for the last year, according to the same man's statistics. He bases this fifty per cent. mortality on seven cases done by Kraske himself, three by Schonborn, one by Rinne, and the remainder by Lauenstein, twelve in all, in which six died as the result of the operation ; some by septic peritonitis (two), some by sepsis (two), and some from exhaustion.

As Dr. Parkes says, there are a large number of surgeons who advocate simply making a colostomy and interfering to no further extent with the case. In some excellent statistics collected by Cripps, we find that out of cases which he watched personally in London hospitals and studied carefully, life was lengthened on the average from seventeen months to twenty-two months—that is, there were five and a half months added to the longevity by simply making a colostomy ; which shows that it is decidedly advantageous. Colostomy, I believe, will aid in lowering the mortality in cases of excision, whether done for pain or for obstruction. As to the operation being of dubious value, there is much to be said on both sides ; there are, however, some well-recorded cases in which, the operation having been performed at an early day, the life of the patient has been preserved. One case was living in 1886 that had been living for seven years since the operation, and no return was to be seen, and five cases in which no return was seen in two years.

It has impressed me that some of the gynecologists of the Society would comment upon the probability of endometritis with infection through the uterine canal and tubes as being very likely to occur in such a procedure, as was exhibited in my patient, and I would like to ask the President whether such an inflammation would be probable in a woman who had passed the menopause.

## Correspondence.

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### OUR NEW YORK LETTER.

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NEW YORK, June 15, 1891.

#### PATHOLOGY OF ECLAMPSIA.

At the last meeting of the Academy, the subject discussed was the pathology of eclampsia and albuminuria of pregnancy. Those who expected to hear something new went home disappointed, and we are still ignorant of the pathology underlying a large proportion of these cases. Dr. Richard Van Santvoord read a paper. He stated that in most cases in which an autopsy had been made, pressure on the renal veins was found. There were, however, cases in which albuminuria appeared too early to be accounted for in that way, and not infrequently it disappeared before the end of gestation. Anæmia and œdema of the brain were believed to be the cause of eclampsia in some instances, and in others hydræmia and high arterial tension. In general, it might be said that two principal theories had been advanced, the reflex and the toxic. The former was based on the assumption that reflex conditions resulted in contraction of the arterioles of the brain. The toxic theory was based on the belief that the disturbances of digestion and of the functions of the liver, so frequent in pregnant women, resulted in an increase of toxic matters in the blood.

Dr. H. C. Coe said that no single theory could be satisfactory from the practical standpoint. In some cases there was a toxæmic condition. In some of these there was probably chronic diseases of the kidneys; sometimes a pyelitis from pressure on the ureters from an old exudation. Such cases were very difficult of discovery. It was important to watch the quantity of urine passed. This was now done at the Maternity Hospital weekly.

Prof. Lusk believed that the objections against the renal origin of eclampsia had never been removed. The kidneys were occasionally found normal, and patients with well-marked kidney disease frequently escaped eclampsia. Anæmia could not be regarded as a cause alone, nor could toxæmia alone. Something else must be added to either. Three classes of cases were met with in practice; those in which there was a sudden stoppage of urine probably from reflex causes, with contraction of the uterus and arterioles; those in which there was arrest of urinary secretion, with disturbance of the reflex centre in the medulla followed by contraction of all the arterioles in the body, including those of the brain; those in which the condition just mentioned existed with anæmia of the great centres, but without kidney trouble. The treatment consisted in emptying the uterus as soon as possible, all other measures being temporary only.

The President, Dr. Loomis, said that though he had not seen many cases of eclampsia for a number of years, he had long ago observed that the danger of a pregnant woman depended on the amount of arterial tension present. A difference in tension was noticeable in different individuals in many conditions, as after a hearty meal or the use of stimulants.

In closing the discussion Dr. Van Santvoord said that he favored the toxic theory. There was something behind the renal trouble, and the high arterial tension which had been so generally noticed. Toxæmia was probably at the root of the trouble. The elimination of urea had not been sufficiently inquired into. It was very easy to determine the quantity, and the fact that it was found diminished in the cases studied by him indicated that it might be a matter of some importance.

#### DEEP URETHRAL CATARRH.

In a paper read at a recent meeting of the Academy, Dr. E. Keyes gave some suggestions for the treatment of deep urethral catarrh. He said that gleet was now recognized to be nothing more than a symptom, very often of a catarrh deep down in the urethra. Even when stricture was discovered and cured the discharge did not always cease, and it was always wise to warn

the patient of that possibility. Usually gleet was a small affair, the discharge being very slight. When posterior urethral catarrh was present, however, it could be demonstrated that there was much more pus posterior to the bulbo-membranous juncture than the discharge would indicate. This was accomplished by washing out the anterior urethra by means of a soft catheter, and then by milking the posterior urethra by firm manipulation in the perineum; if the urine were then passed in two portions, the first would be found to contain much pus, while the second was also turbid. When the prostate or seminal vesicles were involved in the inflammation, the milking process, by means of the finger in the rectum, would reveal the true state of things.

In regard to treatment it could be stated that some cases recovered without local measures, under rest, alkalies, and balsams. Treatment of the anterior urethra had also a good effect sometimes. Many more, however, could be cured only by means of medication applied directly to the deep urethra. This could best be done by means of a proper syringe (Keyes' syringe). There was no danger of inducing cystitis or epididymitis if the instrument were not inserted too far. The tip should stop at the membranous portions of the urethra. The solutions used by him were of nitrate of silver and sulphate of copper, one to ten grains to an ounce. He had used many other substances, but had come to rely on these.

Dr. Samuel Alexander, in discussing Dr. Keyes' remarks, said that he never regarded a gleet as a small affair, for it sometimes produced poisonous symptoms. He also used the deep injections of silver and copper, ten or fifteen drops of either being enough to inject. Occasionally the discharge was increased, and sometimes a solution, as weak as four grains to an ounce, caused pain in the bladder. The endoscope was very useful in diagnosing these deep urethral catarrhs, and he thought it ought to be used. There was a tendency to throw internal treatment over; this was a mistake, however, for it was often very useful.

Dr. G. E. Brewer had used Keyes' method for five years, and had found that many aggravated cases could be cured by the



deep injections of nitrate of silver. He had seen cases in which there was bloody urine, and symptoms indicating stone in the bladder relieved in two weeks by this method.

Dr. F. A. Sturgis was also in favor of the Keyes' treatment. He injected but three to five minims of a very strong solution of silver nitrate. He had also found glycerole of tannin, sulphate of zinc, and acetate of zinc of service. He had used a silver solution as strong as thirty and even fifty grains to an ounce. The sulphate of zinc could be used in ointment with vaseline, by pushing it through the tube of the endoscope directly to the diseased point. This was much better than using a suppository, which contained too much white wax. In spite of all treatment some cases could not be cured.

#### TREATMENT OF GONORRHOEA.

This subject was taken up in the Genito-Urinary Section of the Academy on the last night of meeting. Dr. G. E. Brewer read a paper in which he warmly recommended the use of retrojections of solutions of bichloride of mercury, of varying strength. The method employed by him was to use retrojections of a solution of the strength of from 1 to 16,000 to 1 to 50,000 twice daily. When the acute stage had passed bismuth and glycerine were used. He had treated cases in this way for five years, and had treated by this and other methods about eleven hundred cases. The conclusion at which he had arrived was that the bichloride reduced pain and inflammation, and the liability to complications more satisfactorily than any other remedy. So far as cure was concerned, however, he had discovered that it was uncertain with any treatment.

Dr. Keyes said that he had also come to rely on the bichloride. It was least useful when a posterior urethral catarrh had been lit up into activity anew by a debauch. One difficulty which he had encountered in treating gonorrhoea was the cumbersomeness of the apparatus ordinarily recommended. He had lately overcome this by the use of a small soft rubber bulb, known as Tiernann's Universal Injector. It held about two ounces. He was accustomed to order one grain of bichloride of mercury,

with ten grains of sulphate of potash or other inert substance, divided into ten powders. One of these was to be added to an ordinary tumblerful of water just hot enough to hold the finger in by exerting some will power. It dissolved instantly. The bulb was then filled and the beak introduced into the meatus. By gentle pressure the urethra should be filled until it felt tense; then the bulb should be withdrawn, gentle pressure being continued until the solution welled up around the beak. The urethra should then be kept full until the solution in the tumbler was used up, pressure being made to prevent the escape of the contents, at each renewal of the quantity in the bulb. When the purulent stage had passed, astringents should be used. By this plan of treatment he had found that the discharge could usually be controlled in ten days or two weeks. It was the best with which he was familiar.

Dr. R. W. Taylor believed that it was the hot water which was principally accountable for the success of the treatment referred to. The parasitic treatment of gonorrhœa had been misleading to many minds, and often resulted in forgetfulness, on the part of those who used it, of the simple fact that there existed an intense inflammatory condition which should be treated on the same principles as other inflammations situated elsewhere. He thought that a solution of 1 to 50,000 was inert so far as the bichloride was concerned. The effects were produced by the hot water. A few drops of lead water and laudanum might be added. A two or three per cent. solution of boracic acid was also a satisfactory addition. He thought that there was danger with Keyes' bulb of distending the urethra too much and causing rupture of the mucous membrane. He did not think that deep injections ought to be given as a matter of routine.

Dr. Keyes added that the sensations of the patient indicated that a solution of bichloride 1 to 50,000 was not altogether inert. He usually increased the strength to one-sixth of a grain to the glass of water, and the stronger solutions frequently caused much pain.

In closing the discussion Dr. Brewer stated that he had tried hot water alone, with astringents, and with boric acid, but had

found none of these so useful as the bichloride. It had a marked effect on the discharge. Solution of the strength of 1 to 30,000 sometimes caused burning, and in one instance a solution of 1 to 40,000 caused so much pain as to necessitate the use of cocaine. Sir Joseph Lister had found that a solution of 1 to 50,000 destroyed micro-organisms, while one of 1 to 200,000 prevented this multiplication. It was true that the retro-injection apparatus was clumsy, so he was accustomed to have his patients come to his office twice daily and have the urethra washed out. Where that was impracticable, a No. 18 soft rubber catheter and an Alpha siphon answered every purpose and could be used very conveniently.

Dr. Taylor again expressed doubts concerning the value of germicides, on account of the depth into the mucous membrane at which the micro-organisms were found. To this Dr. Brewer replied that although the germs penetrated deeply they developed near the surface. Dr. Taylor then suggested that the treatment was liable to provoke posterior urethritis. Dr. Brewer did not think so, for any plan of treatment which shortened the duration of the anterior inflammation lessened the chances of air invasion of the posterior portion of the canal.

WM. L. RUSSELL.

151 East 50th St.

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VACCINATION.—Before the vaccination by Jenner was adopted, smallpox was one of the most formidable scourges of the human race, causing a mortality of 10 per cent. Since its general adoption it is less than 1 per cent. During the prevalence of smallpox in Prussia, from 1857 to 1861, nearly eight thousand among the civil population died. The mortality in the army, where vaccination was rigidly enforced, was practically *nil*.

During the period of thirty years just before the introduction of vaccine in the province of Trieste, the deaths from smallpox alone were 14,000 per 1,000,000 of inhabitants, and only 182 during the period of two years which followed the practice of vaccination.—*Weekly Medical Review*.

## Editorial.

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### TO OUR SUBSCRIBERS.

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After considerable hesitation the proprietors of THE JOURNAL have decided to change its title page to the present form.

We hope you will consider that it *improves* rather than *mars* the appearance of THE JOURNAL, and that you will not think that an old, familiar form has been destroyed—at a loss.

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### KOCH'S TREATMENT—AND OTHER TREATMENTS.

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We may say regretfully, that the specific treatment of tuberculosis, as devised by Prof. Koch, is no more. It is now enjoying a condition of innocuous desuetude that is almost oppressive. It is departed, and the places which once knew it now know it no more. Yes, it has gone to meet the gas treatment of Bergeon, and in the land of the Great Departed, among the shades of other deceased medical failures and superstitions, it has doubtless found a congenial companionship in the tar-water of Bishop Berkeley, and the metallic tractors of Perkins.

We believe we are safe in saying that no other therapeutic suggestion or discovery (*sic*) was ever received more confidently and with greater enthusiasm. Prof. Koch states incidentally in August that he has been experimenting upon guinea pigs with a certain substance which conferred upon them immunity to inoculations of the tubercle bacillus and which was capable of ar-

resting the tuberculous process in those already the subjects of the disease. Such an announcement could not fail to excite interest and to create hope. The public mind, both lay and medical, became more and more impatient, until finally under official—almost military—duress, the discoverer was forced to issue to the world his famous letter of November 14th. What happened then is well-known. There followed the most remarkable pilgrimage of doctors which has been seen in the history of medicine. Two thousand physicians, and probably as many patients, immediately flock to the German capital, all eager to possess the new therapeutic talisman. Poetically,

From the four corners of the earth they come,  
To kiss this shrine, this mortal, breathing saint;  
•        \*        •        •        •  
The watery kingdom, whose ambitious head  
Spits in the face of heaven, is no bar  
To stop the foreign spirits, but they come,  
As o'er a brook, to learn of Kochine.

Enthusiasm ran high, and it did seem as if this greatest enemy of the human family had met a capable antagonistic at last. We quote the words of Nothnagel: "We face one of the greatest intellectual achievements in the province of medicine for centuries past. The discovery has a far wider scope than Jenner's, and is, perhaps, the greatest feat in science. . . . The present moment is among the most sublime that humanity has known." So far as the writer knows Prof. Nothnagel has failed to enlighten us on his present views as to this greatest feat in science.

During the past eight months Koch's proposed remedy has received a careful and painstaking trial the world over, under the most favorable circumstances. No other therapeutic agent was ever proposed which met with a more rapid, more widespread, and more thorough investigation. Cases after cases of remarkable cures of the different tuberculous conditions were

quickly reported, embracing all degrees of severity. Hospital physicians rushed into print with their "notes" and "observations." It soon became evident, however, that many patients did not improve, that others were not suitable for this treatment, that others were actually made worse by it. Finally (about April 1st), an official report was issued by the German government which contained some cold arithmetic for the advocates of the tuberculin treatment. Out of 951 cases of phthisis only 13 were reported as cured, 175 markedly improved, 194 slightly improved; 586 not improved and 46 died. Under our former methods of treatment, which were represented by climate, diet and supportive medication, we were able to do better than this. Loomis (*Practical Medicine*) says that one-sixth of his recorded cases (or  $16\frac{2}{3}$  per cent.) during the last ten years have recovered. Out of 640 cases observed by Flint during a period of thirty-four years, recovery took place in 44, or 6.8 per cent. (*Pepper's System of Medicine*.) Against these percentages stands the 1.3 per cent. of the new method.

It may be, however, that the occupation of tuberculin is not entirely gone. There seems to be a field of usefulness for it as an adjunct to other methods of treatment. It may yet be made to accomplish much good when used in connection with favorable hygienic and climatic surroundings. Jacobi believes that the future successful treatment of pulmonary consumption will consist of a combination of climatic cures with a careful and persistent use of tuberculin (*Med. Rec.*, Mar. 7). Such, it appears, is the new method's only hope.

The life history of tuberculin is thus put in a nut-shell by the witty editor of the *Medical Press*:

Act I.—*Eureka.*

Act II.—*Vici.*

Act III.—*Ave, morituri te salutant.*

Act IV.—*De mortuis nil nisi bonum.*

Epitaph—*Fruit.*

To which we will add—*Non omne, quod nitet, aurum est.*

Concerning the other plans of treatment which have recently been devised and practiced, we need not say very much. These may be enumerated as follows: 1. The intra-venous or subcutaneous injection of dog's or goat's serum. This is the method first practiced by Messrs. Herricourt and Richet. 2. The treatment by solutions of iodine and chloride of gold and sodium. Drs. Shurly and Gibbes are responsible for this system. 3. The cantharidinate of potash, introduced by the enterprising Prof. Liebreich. 4. The compressed air treatment of Prof. Germain Sée. Here phthisical patients pass several hours daily in a close chamber subjected to a pressure of an atmosphere and a half. The compressed air is saturated with fumigations of creasote and eucalyptus.

And even these are not all. It has been said of all these plans successively, in a general way, thus: The experiments which have been conducted by Prof. ———, with his new treatment for tuberculosis, have given most encouraging results. Patients in the early stages of the disease show rapid and marked improvement; the distressing symptoms are all relieved and the general condition of the patient is greatly ameliorated. These generalizations, however, do not demonstrate. We are skeptical, but open to conviction. In the meantime we submit the following from Byron:

Thus saith the preacher: "Nought beneath the sun  
Is new": yet still from change to change we run;  
What varied wonders tempt us as they pass!  
The cow-pox, tractors, galvanism and gas,  
In turns appear, to make the vulgar stare,  
Till the swollen bubble bursts—and *all is air!*

## Selections.

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### CARCINOMA LENTICULARE—CANCER EN CUI- RASSE (VELPEAU).

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On the 12th of March, 1890, Mrs. F., aged 55, of Pratt Mines, near Birmingham, Ala., came to me presenting the following history and symptoms : Duration of the disease was about two years. She had first noticed a "hard lump" in the skin of the left breast. About the same time "red spots" appeared in the skin of the left mammary and pectoral region, followed by similar condition on the right breast. In these "spots" papules and tubercles were formed and the skin became diffusely infiltrated. A gland in the left axilla became enlarged and "tender" a few weeks ago. She could not state how long other enlarged (cervical) glands had been so.

At present the skin of the entire anterior thoracic region is involved, the left side, however, more extensively than the right. The right mammary gland is decidedly indurated, the left apparently so, but the skin is so hard, dense, and adherent that the real condition of the gland is difficult of determination. The skin over the gland is quite immovable. Deeply set in this densely-infiltrated skin of the thorax are numerous tubercles and nodules, studding the surface. External to the lateral borders of infiltration are a few isolated tubercles and nodules, circumscribed by normal-looking skin. Some of these are elevated and of purplish color ; one is umbilicated, others are depressed ; the cutaneous covering is movable over them, and they feel like pieces of cartilage set in and occupying the subcutaneous tissue. The color of the "older" portions of the diseased surface is a purplish to dirty-gray, shading off, in a few newer, isolated lesions, to that of the normal skin. The areolæ of the nipples



are infiltrated and slightly scaly, and the nipples are similarly affected, but are not retracted. In the more densely infiltrated area the subcutaneous tissue is as completely involved as the skin, but many of the solitary lesions seem confined to the skin and are freely movable. The tubercular or nodular lesions, both in the infiltrated and non-infiltrated skin, vary in size from a pin-head to that of a small cherry. Many of the larger nodules have in their summit a peculiar round, shot-like, waxy-looking formation. A few dilated vessels can be seen on the surface of some of the lesions. Just beneath the left clavicle there is a reddish, waxy-looking, very hard growth the size of the finger-tip, the summit irregular and showing one or two dilated vessels—the whole appearance suggesting epithelioma. The infiltrated portion is limited below by a line corresponding to the border of the diaphragm, and the edge is as sharply defined as that of a board. The clavicles roughly form a line of limitation above, while a line dropped from each axilla would define the lateral limits.

On the inner surface of the left arm, which is oedematous, an irregular-shaped, deep red, non-elevated patch is seen, very itchy and scaly from scratching. The patient says this is the characteristic appearance and sensation of the skin when it is first invaded by the disease. On the back are two or three similar patches, in one of which slight infiltration appears to have already occurred. Just to the left of the external border of the left scapula is a bean sized, roundish lesion, smooth and of pinkish color, surrounded by skin of normal appearance, none of the "primary redness" of skin being present. (This lesion was excised for microscopic examination, and seemed limited to the corium.) As the disease progresses in the above-mentioned red patches itching is succeeded by pain and a sensation of heat. There is also pain in the breasts. There has not—to this time—been the slightest ulceration in the diseased tissues. Anterior cervical glands are enlarged and hard. Right axillary not involved. Patient has lost a little in weight, but has none of the look of "cancerous cachexia." The only general symptoms are constipation and "dyspepsia."

She is the mother of four children, the youngest now twenty-

four years old. During the lation with her first child the right breast became inflamed, suppurated, and was incised.

The patient returned home in two days. Naturally the prognosis was unfavorable, and the only treatment which seemed to be indicated was that directed toward the general health of the patient. Some months later I learned practically no treatment had been followed. Under date of January 5th, 1891, Dr. G. W. Brown, of Pratt Mines, wrote that ulceration took place in older portions of diseased surface soon after the patient returned home, and "the nodules increased in number and extent." Patient died December 1st, 1890.

*Microscopic Examination.*—The above mentioned specimen was hardened in alcohol and imbedded in celloidin. Sections were stained with "borax carmine" and hæmatoxylin solution, the best picture being obtained with the former. Epidermis normal. In papillary layer of corium a few isolated, scattered connective-tissue and round cells, as may be seen in slight inflammation. About hair-follicles there are collections, in groups of small cells, round, spindle, or irregular in shape. At some points in the papillary layer there are compact groups of chiefly round cells, in which no blood-vessel or capillaries can be seen. The sweat-ducts seem free. The whole system of cutaneous vessels is more or less affected. The papillary branches, the superficial and the deep plexus and their connecting branches are surrounded or completely enveloped by small round cells, among which are seen a few of the spindle variety. These cells invest the vessels in a thin layer throughout their course or expand into groups. The "groups" are especially numerous about the papillary branches. Every visible branch in the field has its cell accompaniment. A little above and also at the level of the sweat-glands are cells of a different type and larger, round, oval, or polygonal in shape, and either in "bands" or roundish groups closely confined by connective tissue. The cell nucleus is clear, and an occasional nucleolus may be seen. These bands and groups of cells, with their connective-tissue covering, are so arranged, as to form a somewhat reticular image. In many of these are to be seen, probably around a capillary, small cells of the type already

mentioned. The character and arrangement of the large cells is such as we usually see in tissues just becoming infiltrated with carcinomatous disease.

The sweet-glands proper were normal, save for the presence of the small cells accompanying their nutrient vessels.

A specimen from an older portion of the disease might have been better, but I believe the one obtained gave a sufficiently clear aid to reaching the diagnosis made.

I will admit that I first believed the disease to be sarcoma, being influenced by the macroscopic as well as by the microscopic appearances (condition of the blood-vessels), and especially by the "primary" redness in areas of beginning disease. A portion of Funk's (*Monatshefte für prak. Dermatologie*, Band VIII., Nos. 1 and 2) description of cutaneous sarcomas fits this case fairly well. He says, under "Early Forms, Primary Efflorescence;" "a. A yellowish-red, red, brown or bluish-red, generally pea-sized macule. Many of these are produced wholly from small tortuous vessels, many are hemorrhagic. The onset of skin sarcoma may frequently be confounded with purpura. b. A millet-seed-sized smooth papule may arise from the macule or its border." Under "c" he says: "The tubercles of sarcoma are generally pea-sized, 'level' (more rarely hemispherical), hard and smooth, dark bluish-brown color. Recent tubercles frequently translucent with tortuous vessels on the surface, of bright color, lesions becoming darker gradually as result of exudation of blood. Older tubercles frequently of the blackish-violet color." Under "e. A diffuse infiltration of the skin," he says: "The affected part is slightly raised, of a bluish-red-brown color, hard, board-like, and not at all or only slightly flexible. Diffuse infiltration generally involves the subcutaneous connective tissue also."

Crocker, ("Diseases of the Skin," 1888) gives the symptoms of carcinoma lenticulare and the stage answering to Velpeau's cancer en cuirasse, and quotes the typical case published by Morrow and Robinson in this *Journal* in Vol. II., p. 1, 1884. This description so well covers the symptoms seen in my case that quotation of further authorities would be superfluous. My mem-

ory of Funk's description first led me to think of sarcoma, and then Crocker's induced a further study, of the symptoms ; and microscopic appearances led to the discovery of the carcinomatous nature of the disease and to giving the age of the patient, the enlarged lymphatics, and the epitheliomatous character of one of the lesions their full share in the symptomatology.—*M. B. Hutchins, M. D., Atlanta, Ga., Journal of Cutaneous and Genito-Urinary Diseases.*

COMPOUND TINCTURE OF CINCHONA IN RHEUMATIC FEVER.—C. C. P. Clark (*Therapeutic Gazette*, December 15, 1890) reports three cases of rheumatic fever treated with Huxham's tincture of cinchona, in which the happiest results were obtained after other measures had failed. One of the cases was that of a boy fourteen years of age; the other two were adults. All recovered entirely in less than a week.

The medicine was given in half-ounce doses every four hours. The author states that he has cured a dozen more patients with almost exclusively the same treatment, and further remarks that the locality of his practice is free from malaria. The effects observed in the disease referred to are attributed solely to the action of the cinchona tincture.—*Univ. Med. Magazine.*

NATIONAL MEDICAL EXAMINERS' ASSOCIATION.—This organization, begun in Washington, D. C., May 6th, has for its object, if possible, to harmonize all the laws of all the States regulating the practice of medicine, so as to adopt something of a uniform standard for all parts of the United States. Dr. J. H. Rauch, of Springfield, Ill., is President, and Dr. L. J. Picot, of North Carolina, Secretary. The other representatives present were Drs. Jerome Cochran, Alabama; C. R. Oglesby, Florida; J. C. Shroeder, Iowa; P. H. Millard, Minnesota; George Homan, Missouri; ——— Cole, Montana; W. P. Watson, New Jersey; W. W. Potter and ——— Payne, New York; and Hugh M. Taylor, Richmond, Va.—*Virginia Medical Monthly.*

ANTIPYRIN IN INFANTILE ENURESIS.—Dr. J. Bouisson (Theses de Lyon) states that the effect of antipyrin in the treatment of

the enuresis nocturna of childhood is "simply marvellous." The remedy is exhibited in doses of 10 grains, repeated to the third time (30 grains in all) at intervals of one hour, commencing four hours before bedtime. Of eight inveterate cases in which the disease had existed for several years, and upon which every other remedy and method of treatment had proved futile, every case was completely cured. Several months have elapsed since the treatment, and in no case has there been a relapse, nor have any symptoms of return been noted.—*National Druggist*.

AMERICAN MEDICAL ASSOCIATION.—The session in Washington, D. C., May 5–8, was a decided success. Officers for 1891–2 are: President, Dr. H. O. Marcy, of Boston. Vice-Presidents, Drs. Willis P. King, of Missouri; Henry Palmer, of Wisconsin; W. E. B. Davis, of Birmingham, Ala.; W. E. Taylor, of San Francisco, Cal. Treasurer, Dr. Richard J. Dunglison, of Philadelphia, Pa. Secretary, Dr. Wm. B. Atkinson, of Philadelphia, Pa. Place of Meeting, 1892, etc., Detroit, Mich., first Tuesday in June, 1892. Dr. H. O. Walker, Chairman of Local Committee of Arrangements.

GONORRHOEA.—I have found nothing equal to hydrastine in treatment of gonorrhœa.

R. Hydrastine, gr. i–ij.  
 Zinci acetatis,  
 Plum.bis acetatis, } aa gr. i.  
 Aquæ puræ.

M. Sig.—Use as injection after washing out urethra with warm water. Internally, alkalies and copaiba.—*McIntosh, N. Y. Medical Journal*.

THE Medical Department of Tulane University, New Orleans, has been the fortunate recipient of \$100,000 from Mrs. Richardson, wife of Dr. T. G. Richardson, Dean of the College. The gift will be used in erecting new buildings.

DR. HOBART A. HARE has retired from the editorship of the Philadelphia *Medical News*, and is succeeded by Dr. Geo. M. Gould.

THE Faculty of the Harvard Medical School have decided that, beginning with the class entering in September, 1892, the regular course necessary to obtain the medical degree shall be four years.

DR. THOS. P. GARY, of Ocala, Fla., died on the 10th ult. Dr. Gary was President of the Florida Medical Association, and one of the best known and most respected gentlemen of the Florida profession.

DR. JOS. P. LOGAN, of this city, died June 2d. During his active career Dr. Logan was universally beloved, and recognized as one of the ablest of the Atlanta physicians. He passed away, full of years and honors.

DR. WM. PERRIN NICOLSON, Dean of the Southern Medical College, was united in marriage, on the 10th inst., to Miss Carolyn Clayton Crane, of this city. The wedding was described by the daily press as one of the most brilliant ever seen in the State. To the happy pair the JOURNAL extends its hearty congratulations and most cordial good wishes.

THE Medical Faculty of the University of Pennsylvania are making an effort to establish the four-year course. To that end, Provost William Pepper proposes to give \$50,000 toward an endowment fund of \$250,000, and \$1,000 annually for five years toward a guarantee fund of \$20,000. This offer is made on condition that an obligatory four-year course of study be established before September, 1893. Other members of the faculty have subscribed \$10,000 toward the guarantee fund, which is intended to cover any deficit accruing out of the new arrangement.

## Book Reviews.

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PRINCIPLES OF SURGERY. BY N. Senn, M. D., Ph. D., Professor Principles of Surgery and Surgical Pathology, Rush Medical College, Chicago; Surgeon to the Milwaukee Hospital, etc. Illustrated. F. A. Davis, Philadelphia, 1890.

The successful study and practice of any branch of the healing art require a thorough knowledge of the principles upon which it is based. The student who has mastered the principles of surgery will have no difficulty in applying his knowledge in practice (preface). It is essentially the *principles* of surgery that are discussed in this volume, such as regeneration of tissue, inflammation, pathogenic bacteria, suppuration, pyæmia, erysipelas, surgical tuberculosis, etc.; and these are handled in the masterly manner which we would expect from the distinguished author. No English work, so far as we know, so thoroughly covers the same ground. Its appearance is very opportune, and we are pleased to see that the verdict of book-reviewers has been uniformly favorable.

THE DAUGHTER; HER HEALTH, EDUCATION, AND WEDLOCK. By William M. Capp, M. D., Philadelphia, F. A. Davis.

This is a book of homely suggestions for mothers and daughters. To the latter it could be particularly valuable, inasmuch as it furnishes a plain and simple instruction on subjects of which girls are too often ignorant. There is not a physician who has not seen cases of inexcusable ignorance of this sort. The fault, after all, rests upon the mothers, and in educating these up to their duty such works as the above may accomplish a very wholesome result. If books such as this were more often read, and more closely followed, there would be more happiness in the family, but less work for the physician. For a practical, common sense talk on subjects too often ignored we commend this little work very heartily.

LITERARY INTELLIGENCE.—The *British Journal of Dermatology*, published by Mr. H. K. Lewis, Gower street, London, will in future be under the direction of a committee, consisting of Dr. H. G. Brooke, Dr. H. Radcliffe Crocker, Dr. T. Colcott Fox, Mr. Malcolm Morris, Dr. T. F. Payne and Dr. J. J. Pringle, the latter of whom will be the acting editor. As these gentlemen will have the coöperation of Mr. Jonathan Hutchinson, Dr. Robert Liveing, Dr. McCall Anderson, Dr. Allan Jamieson and Dr. Walter G. Smith, it will be thoroughly representative of British Dermatology.

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## TO CONTRIBUTORS.

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## Original Communications.

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### THE TREATMENT OF ORGANIC STRICTURE OF THE URETHRA, BY COMBINED INTERNAL AND EXTERNAL URETHROTOMY WITH PERINEAL DRAINAGE.\*

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By F. W. McRAE, M. D.,

Demonstrator of Anatomy and Lecturer on Genito-Urinary and Clinical Surgery,  
Atlanta Medical College, Atlanta, Ga.

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## REPORT OF CASES.

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In the discussion of this subject it is my purpose to confine myself to the consideration of organic strictures of the male urethra not safely curable by simpler methods of treatment. I shall make no allusion to uncomplicated strictures of the penile urethra, nor to those strictures of the deep urethra which may be readily relieved by gradual dilatation.

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\*Read by caption before Surgical Section of American Medical Association, at Washington (May 1891).



That under many conditions external urethrotomy alone, or combined internal and external urethrotomy, are much safer operations than simple dilatation, divulsion or internal urethrotomy, most genito-urinary surgeons are agreed. The conscientious surgeon must, however, meet with cases of stricture which will puzzle him to decide what method of treatment is safest and is most apt to cure the stricture or give permanent relief to the distressing symptoms which it produces.

The literature on the treatment of organic stricture of the deep urethra is so confusing, and the opinions of equally eminent surgeons are so divergent, that the young surgeon is often at a loss to know just how to proceed or who is the safest guide to follow.

There are, for instance, a few eminent surgeons who practice divulsion or internal urethrotomy for the relief of deep strictures, while many equally eminent surgeons condemn these procedures as unscientific, unsurgical and dangerous. And it is with the latter that my observation and experience have led me to agree. About two per cent. of all internal urethrotomies prove fatal, and the surgeon who assures his patient that the operation is devoid of danger must be either ignorant of the facts or willing to deceive.

That these operations are much safer when done according to the rules of strict antisepsis, goes without saying, but that antisepsis makes them safe procedures under all circumstances I think no one will assert.

The dangers to which divulsion and internal urethrotomy especially subject the patient are urethral fever, extravasation of urine and hæmorrhage. Though the danger of urethral fever decreases in proportion to the more nearly the urine maintains a normal standard, other things being equal, we cannot positively prevent its occurrence after these operations, by any known prophylactic measures.

Where, however, the stricture is of long standing, small calibre, irritable, risilient and complicated by cystitis, with ammoniacal urine, the dangers are very greatly enhanced. Given such a case in an old or enfeebled individual and the result of either

divulsion or internal urethrotomy would be, in a large proportion of cases, death, though the operation be done according to the most approved technique.

I do not wish to be understood as arguing against internal urethrotomy in properly selected cases. Nor do I believe divulsion should be universally condemned.

Were it not for the fact that we have better methods of treatment most strictures might be relieved by one of these operations. The question is how are we to relieve those tight, irritable, complicated strictures with greatest safety to the patient and secure the greatest immunity from return? It seems to me the proper answer is, "by combined internal and external urethrotomy with perineal drainage."

To Sir Reginald Harrison belongs the credit of clearly demonstrating the great superiority of this method of treatment over all others in the class of cases to which we have alluded, even where the strictures are readily passable. He has done the combined operations in considerably over an hundred cases without a fatal result or serious complication.

The subsequent histories of these cases were much freer from complications than were those of patients operated upon by either divulsion or internal urethrotomy, and the results more lasting. Mr. Harrison has not met with a single case of return of stricture after this operation. My own experience, though comparatively limited, coincides with his in so far as my observation has extended. As illustrative, I append brief reports of three cases I have recently operated upon according to his method.

CASE I.—Mr. K., *aet* 48, married, engineer. History of repeated attacks of gonorrhœa, cured with greatest difficulty. Since marriage he has had discharge from urethra, often lasting for months, and which for the last year or two has been almost continuous. Was treated for stricture about five years ago by gradual dilatation. Left off using bougies as directed. Several recent attempts—twice under anæsthesia—to pass instrument into bladder had failed. Frequent urination day and night. Urine S. G. 1012 alkaline, muddy, trace of albumen. Deposit

contained abundance of pus, bladder epithelium and phosphates. No casts or kidney epithelium.

Operation St. Joseph's Infirmary (January 11, 1891), ether. After repeated attempts, extending over an hour and a half, succeeded in passing filliform through stricture. Impossible to pass guide over filliform. Operation completed without very great difficulty. Introduced No. 30 soft rubber catheter through perineal wound, to which was attached rubber tube of sufficient length to conduct urine into a receptacle on floor beside the bed. Antiseptic dressing held in place by T bandage. Strict antisepsis throughout. Patient bore operation exceedingly well. Subsequent history, afebrile and without complication. Catheter removed eighth day. Sounds introduced every four to seven days. Patient left the city three weeks after operation, perineal wound almost closed. Passes 32 steel sound without difficulty. When last heard from there was still little escape of urine through perineal opening, condition otherwise excellent. [Later. Perineal opening closed.]

CASE II.—G. K., colored, *aet* 52, married, had gonorrhœa when about twenty, not since. History of difficult urination, with occasional fits of retention, extending over a period of several years. On examination, found one old perineal fistula and scars where others had closed. Tortuous stricture in penile urethra, tough, fibrous in character; dense stricture of small calibre just posterior to bulb, numerous false passages.

Operation before class Atlanta Medical College, January 28th. Ether. Impossible, after repeated efforts, to introduce staff or filliform; always caught in false passages. Finally succeeded in passing No. 10 gum elastic catheter. Operation very tedious. Hæmorrhage excessive; controlled by introducing catheter and packing around with iodoform gauze. Dressed as case I. Catheter removed third day. No subsequent hæmorrhage. Perineal wound completely healed in four weeks.

CASE III.—Mr. D., fireman, *aet* 38, single. Fell astride buggy wheel when fourteen years old, bruising perineum. Had gonorrhœa in 1868, 1875 and 1890. Urinates with greatest difficulty

and at frequent intervals. Occasional chills. On examination, found two strictures of large calibre in penile urethra and one dense stricture of small calibre, only admitting filliform, in membranous urethra. Examination followed by chills and increased difficulty in urinating. Subsequent introduction of filliform one week later followed by repeated violent chills.

Operation St. Joseph's Infirmary, February 10th. Ether. Filliform introduced without difficulty, over which succeeded in passing small tunnelled catheter. Operation completed without difficulty. Dressed as in cases I and II. Catheter removed eighth day. Few slight chills after removal of catheter. Recovery excellent. Now passes 34 sound without difficulty, and perineal wound is about closed, rarely allowing escape of a few drops of urine.

While all of the cases reported might possibly have been relieved by gradual dilatation or divulsion, I am sure they could not have been relieved so quickly, safely or pleasantly by either of those operations.

There is, of course, the remote possibility in every case of producing a perineal fistula, but the probability is so slight as to weigh very little with either patient or physician. Where the strictures have been thoroughly cut the danger of not closing is almost *nil*. I am sure that perineal drainage was of the greatest value in these cases, and that it possesses all the advantages Mr. Harrison claims for it. Patients are rendered much more comfortable by the tube. There is very little danger of its causing cystitis unless it is introduced too far. The bladder should be washed out at least once daily with some mild antiseptic solution. The urine being prevented from coming in contact with the cut and abraded tissues, the danger of septicemia or of urethral fever is reduced to a minimum. Where there is a chronic discharge, the urethral mucous membrane is given complete rest and it is allowed to get well. My results with this operation have been so much more favorable than I have been able to obtain by other methods of treatment that I feel like it should be adopted in the treatment of all organic strictures of the deep urethra not readily amenable to dilatation.

## STERILITY IN WOMAN—ITS ÆTIOLOGY AND TREATMENT.

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BY E. S. MCKEE, M. D., CINCINNATI.

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Your essayist first intended to write a paper on "Sterility in Woman." In a preliminary glance over the field he found he was undertaking a book. Having some regard for the feelings of his hearers, he limited the title to "Its Ætiology and Treatment."

The mariner wending his way over the wide ocean is accustomed now and then to take observations and to find what progress has been made, or how far, if any, he has drifted from the proper course. The oftener and the more carefully he makes these observations, the less will be his deviations and the sooner he reaches the desired haven. So with us is it wise from time to time to consider what we have done, even though the way we travel may be well worn and apparently barren and unfruitful.

If is only in rare instances that the lack of descendants is not sooner or later regretted by both husband and wife, and it often proves an opening of the door to marital discord and reproaches, with all their evil consequences. Sterility, among the old Romans and Israelites was sufficient cause for dissolution of the marriage relation. Instances of human sterility due to want of sexual harmony are exceedingly rare, and most cases supposed to be of this nature can be otherwise explained. The ætiology of primary sterility is often "shrouded in darkness," and the successful treatment of the same past finding out.

Sterility in man must necessarily be eliminated before we can be assured of success in treating the woman. A few years ago man was supposed to be able to beget children in almost every instance. Gross has proven otherwise. His statement that one case in six is due to sterility on the part of the man is probably too strong, yet it is not greatly wide of the mark. We can not believe, as we did a few years ago, that the paramount

source of sterility is in the female. Kehrer, after a series of carefully conducted experiments, has arrived at the conclusion that "in at least a third of the cases of sterile marriages the husband was the party at fault, and gonorrhœa the cause of the barrenness."

The most frequent origin of sterility is, perhaps, intra-uterine disease, and chronic endometritis is its usual manifestation. This disease may act by giving rise to the characteristic profuse gelatinous discharge, thus hindering the ingress of spermatozoa by destroying the vitality of the spermatozoa. This renders the mucous membrane unfit for the fixation and development of the ovum. This diseased condition of the intra-uterine mucous membrane may extend into the Fallopian tubes and obliterate their orifice so as to prevent the admission of the spermatic fluid. It is well known that constitutional causes, more especially the scrofulous diathesis, have much to do with these inflammations; also cold and heat, overfeeding and underfeeding, youth and old age, lowering of general health, confinement and interbreeding.

Diligent study of the subject of sterility demonstrates that inflammations of the pelvic peritoneum, and of the parametria, or rather their consequences, are among the most frequent causes of sterility. Anatomical researches very frequently find such considerable adhesions between oviduct, ovary, uterus and rectum that conception would be an absolute impossibility, yet other adhesions exist which might not prevent impregnation.

Three questions are to be determined: (1) Are spermatozoa in the semen? (2) Do they get into the utero-cervical canal? (3) Do the secretions in the canal poison the spermatozoa?

Microscopical examinations were made by Roy, of Munich, of the condition of the spermatozoa at different intervals after coitus, in sixty women who were under treatment for sterility. In fifty-seven catarrh was present. In all of these cases only a small number of spermatozoa could be detected within the uterus, and they had all become motionless within five hours after coitus. In healthy women he had found that the movements of the spermatozoa within the uterus continued for at least thirty-six hours.

It is probable that if the secretions are normal the spermatozoa can make its way into the uterus in spite of flexions or stenoses.

We learn from physiologists that the healthy spermatozoon in a normal vagina may live and retain its vitality for seven or eight days; that its lateral diameter is one forty-two hundredths of an inch, and that it will be able to penetrate any orifice through which a red blood corpuscle can pass. Its rate of travel is about seven and a half or eight inches in an hour, sixteen feet in a day, or thirty or forty yards in its lifetime. These facts would lead us to doubt if long or narrow or ante or retro-flexed cervixes could primarily have anything to do with sterility.

Vulvar or vaginal hyperæstheria, inflammation of the carunculæ myrtiformes, undue shortness of the vagina, unless great care is exercised by the husband, will induce dyspareunia and may also bring about sterility by favoring the formation of a copulative sac outside of the axis of the uterine canal, and consequent destruction of the semen.

Infantile uteri and other malformations are frequent causes. Malformations of the vaginal portion often prevent conception in women as well as animals.

A Chicago professor stated in a clinical lecture that it had been his observation that in sterile women the hair on the mons veneris was always straight. That curling the hair would cure the sterility was not demonstrated.

Premature and post-mature marriages seem to tend to sterility.

The infertility of heiresses is well known and goes to show sterility to a certain extent inherited, if inherited sterility is not a contradiction of terms. This is one way in which persons become rich—property increases, children are few.

The female being less passionate than the male the orgasm comes later with her. We can, with reason, suppose that conception is more liable to occur were it to happen simultaneously. The male orgasm occurring so early, the female may not reach that state at all.

Obesity is especially regarded as a potent factor in sterility, and the state of nutrition in woman, as in plants and animals, has long been known to have this tendency. Some have attempted to ex-

plain the connection between obesity and sterility by the direct pressure of the fat upon the ovaries.

The more plausible theory is that the extensive disposition of fat deducts from the developmental process in the organs. The interference with menstruation which we observe so often in fleshy persons points in this direction. It is probable that the ovaries are not organically affected by this condition, as the normal menstrual flow generally reappears when the obesity disappears. Examination of the ovaries, under chloroform, in obese persons, will show their organs intact, and it is probable that obesity causes sterility indirectly by hindering the expulsion of the ova and not their development.

The injurious influence of fatness in women, as regards child-bearing, is universally admitted, and is corroborated by experience with plants and the lower animals. Young women, upon commencing to breed, are fat, or at least plump. When they bear children they lose in weight by diminution of fat, and when they again cease to bear children they regain their fat with compound interest. This premature and post-mature fat is, to a certain extent, an indication of health.

When it attains a condition of polysarcia obesity has a great influence on generation. In the male, its early development checks the growth of the genital organs, and if late diminishes sexual desire. The accumulation of fat in the abdomen is claimed by some to exercise an injurious pressure on the utero-ovarian apparatus.

The hypertrophic condition of the external genitals in obesity may form a mechanical hindrance to impregnation. Given an obese woman, we will generally find that the prospect of offspring will depend more upon the menses than the amount of fat, amenorrhœic fat women being usually sterile. Statistics show a diminished increase in population during famine, but it is only ephemeral. Thinness only affects fertility when it is depends upon some chronic disease.

Over feeding and luxurious habits have not a little influence on sterility. It is a matter of common observation that the laboring classes, among whom destitution frequently prevails, are



much more fertile than the more wealthy. The indolent and luxurious mode of life prevalent among the rich diminishes fertility, while this condition is favored by the laboring habits and diet of the poor. The proportionate fertility of the classes is stated by Marshall Hall to be six to one.

Venereal diseases have their share of influence, and the gonorrhœal affection is a potent cause of sterility, but it is by no means proven that syphilis has any unfavorable influence on conception, though the frequent abortions due to this or other causes may lead to this result. Syphilis is often associated with gonorrhœa, which is the real cause. Gonorrhœa frequently prevents conception by the inflammation traveling up the womb along the fallopian tubes and renders the covering of the ovary thick and tense, so that the ovum cannot escape, or, if it does, the fimbriated extremity of the tube is so agglutinated that it cannot rise up to grasp the ovum. The extreme views of Magrath, that the wives of men who have had gonorrhœa, as a rule, remain sterile, have not been extensively accepted by the profession.

Reflux of semen after coition was described as a cause of sterility by Hyppocrates and Loranus, and is probably a frequent cause, though, doubtless, many women base their complaints on a delusion.

This *profluvium seminis* is rarely complained of except by the sterile and is unfrequent among the fertile. It is also believed to be common among those sterile women who have no sexual pleasure. It is probable that the mucous discharges of the glands of Cowper or Dunerway are in some cases mistaken for semen.

The vaginal secretions under certain pathological conditions become so acid that it induces sterility. Women who suffer from severe vaginal catarrh are frequently sterile; the spermatozoa being found dead in the vagina some hours after copulation, though on examination, a shorter time revealed them still alive. This vaginal secretion, which is the *materia peccans*, may also act in a mechanical way. In cases where conception occurs, despite a very acid condition of the vaginal secretion, it is probable that

some of the spermatozoa enter the uterus before the secretion has time to act on it, or possibly the spermatozoa being injected in a mass, the acid secretion is unable to penetrate and kill all of the spermatozoa.

Chlorotic women often conceive and sterile women just as often show no other cause for this sterility than chlorosis. Scrofula, probably by its effect on the general system leading to a deficient development of the entire body, genitals included, may be productive of sterility. Tuberculosis is, probably in all except its later stages, without effect on child bearing.

Alcohol has been considered as having a great influence on sterility in women. It evidently does diminish sexual potency in the male, and for this reason is largely blamed on the female. By causing general constitutional disorder and a chronic inflammation of the ovaries, it possibly does occasion a certain amount of sterility. Yet we see numerous instances of parents addicted to the abuse of alcohol who have large families of (very ragged) children.

Carcinoma cervicis uteri is an important obstacle to conception. When the growth has advanced to any degree, even if confined to only one wall, the cervical canal is mechanically stopped and the corrosive fluid which accompanies ulceration has a deleterious effect upon the sperm.

The higher education of women has been held to be a feature in the production of sterility. However, the experiment is one of rather too recent date to be of much certain value.

Ovulation is doubtless more perfectly and frequently performed in some women than in others. Some conceive with more or less regularity every fifteen or eighteen months, and others at intervals of several years.

Dysmenorrhœa among the fertile is comparatively uncommon. Nearly half of sterile women suffer from dysmenorrhœa. The association of this neurosis with sterility is not unimportant. We often have also the return of semen and derangement of sexual orgasm or coitus and the cure of the dysmenorrhœa is a direct step toward the cure of sterility. Some claim that two out of five cases of sterility are accompanied by spasmodic dysmenorrhœa.

Emmet in his tables shows that of all married women who suffered pain during menstruation at puberty, seventy-one per cent. were sterile.

Sexual incompatibility is well known to exist, prominent examples being Angustus and Livia, Napoleon and Josephine. A case is reported by Duncan, where a man married successively three childless widows and had children by each one of them, and another, where a woman is married successively during child-bearing limits, to three men, and has children by but one of them. Sterility from sexual incompatibility, we cannot foresee or prevent, and religion, morals and law interdict the cure that might result from a change of husband. Among some classes in Wales and Scotland, for instance, custom permits and local morals do not condemn a practice which produces many illustrations of this mutual incompatibility. This practice is called bundling, or keeping company, and consists in permitting young girls to cohabit with an eligible man, on the understanding that, if pregnancy ensues, the legal marriage tie is made; progeny not resulting, the woman is deserted by her friend and falls to another with whom the result may be different.

Sexual incompatibility, or want of sexual unity, the so-called relation sterility, is the condition in which long and regular cohabitation between two individuals remain without result, though each one can pro-create with other individuals. Some marriages remain long sterile, are dissolved and both men and women produce children in another marriage. Duncan has found that many more women relatively who marry between the ages of fifteen or twenty are sterile than those who marry after twenty.

Sexual sensations, lack of participation or feeling, seems to have no especial influence on conception. Many women who have no passion conceive rapidly; others who have, may not conceive at all. Dyspareunia or frigidity does not occupy a very important role in sterility, though they do doubtless in some cases. Among prostitutes, the frequent delay of menstruation, then abundant hemorrhages are in many cases only habitual abortions and lead to changes in the genitals which must result in sterility,

The effect of nervous or psychic influence on sterility through its suppression of menstruation, as we cannot reject the idea of a connection between ovulation and menstruation, doubtless is of some considerable moment and merits further investigation.

The Druidic college of the 12th century considered tannin a most potent cause of sterility, hence excessive tea drinking might act in the same way. Sulphur is also believed to have the same effect.

Such dislocations of the cervix may occur that instead of lying in a pool of semen as it should, it lies above, in front, or away from it, and this may prevent conception. Sterility can be occasioned where necessary by obliterating the uterine extremities of the fallopian tubes with the thermo-cautery.

The universal prolificness of Arkansas is well known and if you ask down there why they have so many children, they will reply that the mosquitoes are so bad that they cannot sleep at night. That mosquitoes are a stimulant to reproduction is hardly proven, but that they act indirectly is firmly believed in Arkansas.

Montagazza, Bondin and Balley wrote that consanguineous marriages tended towards sterility. Darwin, after a most thorough investigation, using as his guide Burke's "Landed Gentry" and "Peerage," finds that consanguineous marriages are slightly more fertile than the non-consanguineous. He is of the opinion that this is because marriage between first cousins is more apt to take place where there is a large group of persons who bear that relationship to each other and this fertility becomes hereditary. The alleged infertility of consanguineous marriages cannot be substantiated.

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## FIFTY YEARS' EXPERIENCE IN OBSTETRICS.\*

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By JOHN S. CLARK, M. D., CHICAGO, ILL.

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MR. PRESIDENT AND GENTLEMEN—When I set out to write these my obstetrical reminiscences and conclusions, in a rather disjointed manner, as I could catch time in the intervals of pro-

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\*Paper read before the Chicago Gynecological Society, February 20th, 1891.

fessional business, it seemed quite a long and, as I thought, rather a disagreeable article, going much into detail; and it was long and dry and tedious. I had not gotten half through with it when I remembered how much I had suffered in acquiring the knowledge and facts set forth, and I felt I had no right to inflict upon you gratuitously what I had endured and been paid for; so I set about, rather late in the day, to summarize and shorten my article, and found the last day, and in the afternoon, before it was two-thirds finished.

This is the Golden Age of the obstetric art. When Zeuxis and Apelles were painting those wonderful pictures which deceived birds and animals, and Phidias and Lysippus carving those colossal statues of gold and ivory, many of which were sold for their weight in gold—at that time, which has been by many considered the Golden Age of the fine arts, one art was far behind.

Hippocrates, who was a contemporary of these artists, begins his celebrated aphorisms with: "Life is short and the art long; the occasion fleeting, and experience fallacious, and judgment difficult. The physician must not only be prepared to do what is right himself, but also to make the patient, the attendants, and externals co-operate."

I quote the whole of the first aphorism, so wisely, so nobly expressed. But our art was then in its infancy, comparatively, as I will illustrate by another quotation from the same great man: "When the child presents double at the mouth of the womb, it should be pushed upward so that the head may come down.

"When a hand or foot protrudes it is to be pushed up in like manner, and the head made to present."

When, in feet presentations, the head is retained after the body is delivered, he advises us "to introduce a hand between the os uteri and the head, and deliver it."

When the secundines are retained, he orders us "to extract them slowly," and for this purpose directs that, the woman being placed on a stool, the child not having been separated, it is to be allowed to hang down, so that by its weight it may produce sep-

aration; and, "lest its weight should occasion too strong pulling," he advises "it be laid on wool, or bladders filled with water, so that when perforated the child shall sink down gradually and draw away the placenta."

Celsus directs us, "in arm presentation, to pull down the head with a hook in the eye, the ear, the mouth, or forehead."

Aetius gives as a cause of difficult labor, "A too compact union of the *ossa pubis*."

According to Eros, difficult labor is due to "tumefaction of the external parts," for which he advises "a sitz bath prepared with emollient herbs."

Avicenna states that the expulsion of the child is performed by the abdominal muscles, and this was the opinion of Galen. He directs baths before and during labor, and advises the "use of forceps in difficult labor, the child to be extracted by them." "This," says Francis Adams, the translator of the works of Hippocrates, "proves that the Arabians were acquainted with the use of the forceps."

Haly Abbas mentions imperforate hymen among the causes of difficult labor. Baudelocque reports such a case, so does Burns, and I too have had a case; of course the hymen was not imperforate, but was unruptured.

Haly Abbas directs, in rigidity, to "make the woman sit in a warm bath prepared with chamomile, etc., and to take internally an infusion of swallows' nests"—probably the edible birds' nests so valued by the Chinese.

So much for ancient midwifery. Nor did it improve much through nearly two thousand years. With the discovery of the art of printing began a new era in the arts and sciences. The ease with which one able man and close observer transmitted his knowledge to his fellow-men, and he in turn to his followers, thus exciting a noble emulation, soon brought our art rapidly forward, and we have works, written a hundred years ago, varying but little, and in minor details only, from our present and almost perfect state.

To this great teacher and best illuminator, the art of printing, discovered about 1450, almost coeval with the discovery of our

country, and which has done for the minds of men what our land has done for their bodies, do we undoubtedly owe our rapid and brilliant advancement in the arts and sciences, more especially our own art, which has kept so well up in the race that it is now considered well-nigh perfect. It makes me proud to read such a book as that, say, of honest James Blundell, with his repeated warning against "meddlesome midwifery"; to read his direction for the management of everything that may happen to you as an obstetrician, and to know by your own experience that everything he says is true, his advice pure gold. He lectured eighty and more years ago.

Denham, too, so reliable and satisfactory; Cazeaux, one of the most complete manuals ever printed—you never look in him in vain; Velpeau, valuable for the neat manner with which he gives us the benefit of the enormous experience of those wonderful women, Mesdames Boivin and La Chapelle. The lively Gorch, and the sound, reliable, painstaking Ramsbotham, and in this country the patient, indefatigable Dewees, the brilliant Meigs, and last, but not least, the invaluable Lusk—these books, glorious monuments to their authors, better than "storied urn," stand on the shelves of our libraries or lie conveniently at hand on our office tables, generally well thumbed; and we all know that they made us, and we owe them to the press—the printing press.

During the early years of my professional life I went to every case of childbirth with dread and fear of an impending calamity. I constantly read the dear good writers upon the subject, and faithfully followed their teachings. I was watchful, patient, and tried not to be meddlesome. Years of success gave me confidence, and I have come to be, perhaps, too far the other way—too easy and sanguine; but I never go to a case, even now, without something of the feeling of a man going to jail—a man going to be "confined" himself. The leaving of a pleasant home for an uncertain time, the dropping of every other pursuit, the going to reside in the abode of anxiety, uncertainty, and misery make the life of an accoucheur one of great self-denial and often of downright physical and mental endurance; and yet

the happy ending of a bad case, "mother and child as well as could be expected," is a most delightful experience and pays for all.

I graduated in January, 1843, at Geneva, N. Y., and, with the exception of a three months' trip to Europe in 1855, have been constantly busy in the practice of my profession ever since. During that time I have attended, in round numbers, three thousand five hundred cases of childbirth. I never saw a woman die in actual labor, and was never called to a case that I left undelivered.

I divide my time into three periods—the first of thirteen years, while a resident of a thriving and beautiful town of some five thousand inhabitants in Central New York, where I attended seven hundred cases, none of which were of sufficient interest to be worthy of especial mention. No placenta previa, no arm presentation, no eclampsia—two face presentations being the most troublesome I met with in those days. I was shy in using forceps, having too much trouble in making them lock, not having then learned the trick of depressing the handles. I only recall three cases in which I used them. It was there I learned how nature, if given time, would overcome what seemed insurmountable obstacles, moulding and shaping the soft, yielding head till it would travel through a strait at first deemed impassable. I had but one death there, from what I now know was uremic poisoning. It occurred thirty hours after labor.

In this city, from 1856 to 1871, I had quite a large obstetrical practice. All records were burned in our great fire, but I am sure I place the number low enough at fifteen hundred cases. In 1857 I had my first arm presentation—a midwife's case, who had dallied with it all day—but kind nature, as she most always does in preternatural presentations, had withheld hard pains, and the turning was easy and quite successful.

The bugbear of my existence had been for years placenta previa, and one stormy, dismal night in March, 1859, I found myself confronted with such a case in a remote place in the Rolling Mill district. There was much flow and a small, rigid os. I tamponed at once with extra care, and sent a messenger for



Dr. Clark, of South Halsted street, a capable, reliable man of the old régime, lately deceased. Dr. Clark had attended the mother with her previous children, and when I explained that the present was one of the most dangerous incidents that could befall a poor woman during child-bearing, the family wanted him sent for, and so did I. After a few hours the tampon began to leak badly and the pains were severe. The doctor had not yet arrived, but so much blood had been lost I dared not to wait longer, so removed the tampon and found an easily dilated os which readily admitted my hand, the placenta barely covering it. The turning was easy, my arm preventing the escape of the waters. The child was dead; and I will say now that, out of eight cases of placenta previa which I have attended, I have delivered but two living children. The next case of the kind followed this one in a few months, and is only interesting from the fact that, being a midwife's case, she had risked it until the head, pressing pass the placenta, had checked the flow and the labor proceeded naturally. I have attended a lady twice with placenta previa; in both cases turning was easy, but in the last the patient lingered three weeks and died. I was not able to define satisfactorily the cause of her death, nor could the eminent counsel who saw her with me.

Of arm presentations I recall seven cases; all turned easily, but the death rate of the children was high; either three or four died.

For the next period, from 1871 to 1891—twenty years—I have my visiting lists, and from them I gather that during that time I attended thirteen hundred and odd cases, of which a disproportionate number were instrumental. I have for many years been called upon by German midwives in my neighborhood to deliver their bad cases, or extract adherent placentas, or turn out clots in internal hemorrhages, and this should give me a broader margin of percentage for losses; and yet I shall not claim it, for there has actually been no loss. As I said before, I never saw a woman die in childbirth, and I have often asked my professional brethren if they had, and almost always the reply is in the negative. But I have had three deaths within

twenty-four hours after labor—one at six hours, from exhaustion following a breech presentation. The patient, a very unhappy young widow, pretty and fat, tired of life, would not make an effort, and the labor, a dismal failure all the way through, was finished at last by a blunt hook, leaving her completely exhausted. She could not rally, and died at the end of six hours. The next fatal case was an arm presentation; the woman a poor, dissipated, broken-down creature, who, with a midwife and attendants much like herself, had been in labor all night. I saw her at noon, and had no trouble in turning and delivering, and left her quite happy at being out of her misery. I found, in the morning, that she had died at daylight, dropping off so easily that it was believed she had fallen asleep. The third case I do not remember so well, but think it was simply a tedious labor. The patient died twenty-four hours after delivery. They were all three simply cases of exhaustion. These, and the uremic-poisoning case in New York and four other cases—one of which was a most interesting case of pyemia, in which death occurred thirty-five days after delivery, and which was worthy of a long, and full report—are the only ones of death from the dangers of gestation or delivery that I can at this time recall in my whole experience.

Twice I have felt compelled to use perforation. The first time was in a frontal presentation, when, for some cause, we could not make the forceps hold. The next was in a vertex presentation, with face in the hollow of the sacrum. It was a curious case—a heavy, stolid German woman of forty. She had been delivered of three stillborn children, and I had had the good luck to deliver her of a large, fine living child—forceps delivery—two years before. In her fifth confinement the presentation was good, and, after waiting long and giving her a fair chance, I applied the forceps. If I had tackled the Rock of Gibraltar I could not more signally have failed. Then I thought of the best doctor for physical strength within reach, and he was sent for. He tugged away till he was tired out, when the family remembered a remarkably skilful “little” German doctor, who, after a short trial, concluded he could not do it, and we put our heads

together and settled on craniotomy. The family would not consent, and another eminent and stouter German doctor was sent for, and he bothered us for hours, trying and resting, and trying again. He finally gave in, and we settled down to the perforator. The baby had been dead for hours. After reducing the head to the smallest dimensions possible with the cranioclast, we could not move it. We removed the frontal and parietal bones, and by that time there was a slight gain, and after mutual efforts, that lasted altogether three hours from the time I sat down with the perforator, the brave patient was delivered, nor was there any very serious trouble afterwards. She was in bed three weeks, but has never conceived again.

I cannot recall a single death or serious harm following a forceps delivery. Since learning to use them neatly, I apply them earlier than I used, but always give Nature a good chance. In my midwife cases I satisfy myself that they are necessary before using them. I often have patients who cry out for them when I enter the house. I use them slowly, imitating nature. I do not consider an hour or two out of the way at all, and I have had them on and off for a day or two, once or twice, with a perfect recovery of the mother.

I have been peculiarly fortunate in regard to hemorrhages after delivery, never but once knowing that my patient's life was in great danger. It was a most interesting and instructive case, but too long for this article. Only once in my entire experience have convulsions seized my patient during labor, or before or after. She recovered, the baby stillborn during coma. I have seen a dozen or more cases in consultation; at one time I had seen seven consecutive cases that had recovered. I have much faith in venesection, but there are cases I would not bleed. I have not been a strenuous advocate for hurrying delivery; Nature almost always delivers. That it is a "*sine qua non*" is absurd.

I have had two cases of encephalic monsters; they did not disturb the course of events.

Spina bifida has been a rare event to me, two cases only that I recall.

I used anæsthetics in labor much more frequently formerly than now. I fail to see their value in most cases, and only use them when the os is, from any cause, very tender and sensitive, or when I am about to undertake a painful obstetrical operation. I have patients who insist upon their use, and in such cases yield gracefully and do the best I can. If not carried to complete anæsthesia, the use of them does not often interfere with the progress of a case, and serves to divert the patient from a too complete consciousness of her pain. But, owing to the varying susceptibility of women, it is not always possible to stop at exactly the right point, and quite lately I have lost a child, a fine, stout boy, from my patient passing to complete anæsthesia (in an instrumental case) the moment the baby's head passed the external soft parts. Now, while it is allowable to make tremendous traction with the forceps upon an undelivered head—the shoulders easily following the head—after the head passes the vulva the situation is completely changed. The shoulders now have to overcome the resistance of the soft parts, and, unless our efforts at extraction are backed up by good, strong, expulsion pains, it cannot be done by any amount of tension we may safely apply to the head, and the blunt hook is the instrument we have to depend upon. In this case my patient was noisy and troublesome till the head was delivered—having had but a few drops of chloroform—but the moment the head was delivered she became completely insensible. The child, a very large one, lay face downward, and the sphincter caught him as neatly as any garroter could have done; he gasped for breath two or three times, and though I had a good blunt hook at hand and quickly applied it, at the same time trying to take off the compression of the soft parts, did not succeed in delivering until the child was hopelessly gone. If I had had another blunt hook, with the two I could have delivered sooner. I had delivered this woman three times previously, with forceps, of living children, but without chloroform.

I have used ergot quite frequently ever since I began to practice midwifery; at first in inertia only, viz., when pains were feeble; of late years for other purposes, principally for hemor-

rhages. I have never seen harm result from its use, save in one case over forty years ago. In a tedious case, with the os well dilated, the ergot acted most violently. I have never seen anything like it since. The child was stillborn, and no doubt the use of the forceps would have been much better. Midwives having too much to do use ergot constantly to hurry their cases; and if you happen to get a patient formerly attended by a midwife, the chances are that your case will make but little headway until you use it, the patient having acquired what may be called the ergot habit. I have seen dozens of such cases, using ergot for insufficient pains; one should have the forceps at hand. But why use ergot in such a case at all? The forceps skillfully applied is safer for mother and child. I never knew the mother to die after a forceps delivery, and very few children. I am sorry I am not able to say exactly how many, but I am sure I have not lost a baby that way for years, except the one just mentioned as lost through the use of chloroform during the instrumental delivery.

I have attended a lady with all her children, ten in number. The first seven were under ten pounds weight, easy, natural labors. Then the mother grew fatter, and the last three children weighed fourteen or fifteen each, with long, tedious instrumental labors. In the last one, the largest child and the most tedious labor, the child stillborn, I was over an hour in delivering the shoulders.

I have delivered a few times from above the superior strait; cannot say how many times; can recall two instances and know there were more.

It would not harmonize with Nature's perfect work that a woman, in carrying out the principal object of her existence, the continuance of her species, should lose her life in giving birth to her child. Our artificial, luxurious mode of living, our refinement and cultivation, and development of the sentiments and emotions, and fineness of figure and fibre, render our women more liable to danger and disaster in child-bearing than when living plainer. But, fortunately, modern science has given the physician almost perfect methods of relieving her from nearly all the ills that female flesh is heir to, and I have a conviction that there

is nothing that can happen to women in which there is so little danger as child-bearing. And if women were taught this wholesome truth it would entirely change the color of their lives. Another conviction is that the pains of childbirth are enormously exaggerated in the vast proportion of cases. I have noted this fact in a great number of cases, and nearly all the ladies, when asked about the amount of pain, at the time have said it was much less than they had expected, and a few, a very few, have said "it is nothing at all." But there is this curious contradiction, that, while willing to speak lightly of the pain at the time of labor, when asked about it afterward all have said, without exception, that it was simply awful. So that it seems their testimony cannot be relied upon, and we have to draw our own conclusions; and, as I said before, from what I have seen I do not believe that in the majority of cases there is such severe pain as is usually supposed; and if we can make young women believe this too, we shall brighten the complexion of their lives and lessen the number of cases of abortion, of which I am about to speak. But before doing so I wish to bear testimony again to the value of the early and prompt application of the forceps in cases of threatened, tedious, wearying labor. They are but a pair of thin, elegantly made steel hands, which, backed by strong arms and skillfully applied, do better service in the cause of women than ever did those bright Toledo blades that cut such a figure in the annals of chivalry. For both mother and child we may say, as Sir Walter Raleigh said of the axe used to behead him, "It is a sharp medicine, but a quick cure for earthly ills."

#### ABORTION.

As nations grow more powerful and prosperous, and individuals devote themselves to the getting of wealth that they may lead lives of luxury and pleasure, a disposition to regulate the size of the family prevails, and the slaughter of the innocents begins; so we may say that abortion, like the free use of salt, marks a high degree of culture and civilization. It is not necessary to say anything of the causes of abortion, which are as various almost as the cases. But I have had opportunities of seeing some

curious and interesting results following "criminal abortion" which will interest you, and I will mention them.

In several instances fine, healthy, handsome young women, quite recently married, found themselves in the family way earlier than suited their views, and caused criminal abortions to be procured. It was interesting, years afterwards, when they desired to be treated for sterility, to learn from them the story of their folly. They had lost the ability to conceive. It was as if violated Nature required years to recover her propriety.

In two of the cases the mothers of the young women had not only sanctioned the crime, but had gone with them to the abortionist. Many years ago I was the physician to a lady, mother of three healthy children, who became one of what I may call a colony of abortionists. A cultivated and accomplished young married lady with one child had moved into the neighborhood, and soon taught a number of the ladies, her more intimate friends, the art or trick of rupturing the membranes with a goose quill. My patient was one of the initiated. I will not attempt to say now how often I attended this lady with her abortions in the few following years; she had acquired the habit, and abortions would recur in spite of her. As soon as she discovered this it became the end and aim of her existence to have another living baby; it was years before she succeeded, then in less than a month the baby died with convulsions, and another and another succeeded, each succeeding one attaining greater age and the mother proportionately more fond. It was the most pitiful sight I ever saw, this anxious, pale, sad-faced mother watching those delicate children as they drooped and died. Finally one lived, a sturdy fellow, who as a child was the terror of the neighborhood, as a young man was a thief and could not be trusted in any way. In such manner may geniuses for good or evil be made. The lady who so thoughtlessly corrupted her friends is long since dead, though descended from a long-lived race. She was ambitious and desirous of a social position; they had been poor, but worldly matters went well with them, and she might have been living now, a happy grandmother, but for this most unhappy turn in her affairs.

I am not able now to say how many cases of abortion I have

attended. If I put them at twenty a year it would make the number a thousand; but when I say I have had four cases in the past month, and have always had a good number, it would not, at all events, be out of the way to say six hundred cases. I believe there were more—well, say six hundred; and when I add that I never saw a woman die from hemorrhage in abortion, a valuable and interesting fact is stated, and one which should bring a goodly degree of comfort to the unfortunate doctor who is compelled to attend these doubtful, confusing, tormenting cases. And speaking of hemorrhage reminds me that a former patient, mother of one child, much to her annoyance failed to menstruate at the proper time, and a month or two later, to her great delight, found herself flooding so violently that I was sent for. I put her to bed, enjoined rest and perfect quiet, and gave her an opiate. She lost an immense quantity of blood, large clots coming away; she hoped everything had passed. The same thing happened a month later. I did not see her, but at the proper time, six months afterward, delivered her of a fine healthy child.

It is astonishing how long a time, occasionally, will elapse after the death of the fetus, before it is cast off. I have had a case where three months passed after its death before it was expelled, the patient troubled all the time with a pink show. It is not necessary or desirable that I should say much about the treatment of cases of abortion; we all treat them similarly. I have found the hemorrhage easily controlled by the well-fitting tampon, and have never seen harm from its use. If the ovum is long retained and hemorrhages occur, we should try to get it; for, once the ovum is turned out, the bleeding ceases. I have known the ovum retained twenty-eight days, and finally discharged with very little show, perfectly inodorous and unchanged; and Dr. Hasbrouck, of Nyack-on-the-Hudson, reports a case retained sixty-five days. If decomposition takes place, and there are very offensive discharges, and the os open, and the cavity of the womb easily reached, I should say by all means turn it out; but if the external os is tightly closed, I should hesitate to invade the sanctuary on which Nature has written, "No admittance." From a great number of cases that I have had of retained decomposing ova



which came away or were absorbed without harm to the patient, I have come to have little fear as to the result.

In a little book entitled "The Physician Himself," written by Dr. Cathell, of Baltimore, and dedicated to Professor Austin Flint, Sr., I find these golden words :

"When you are importuned to produce abortion, on the plea of saving the poor girl's character, or to prevent her sister's heart from being broken, or her father from discovering her misfortune and committing murder, or to prevent the child's father from being disgraced, or to avert the shame that would fall on the family, or the church scandal, etc., etc., or to limit the number of children for married people who already have as many as they want, or for ladies who assert that they are too sickly to have children, or that their suckling child is too young to be weaned, etc.—you should meet them with a refusal as cold as ice, and never even seem to entertain the proposition. If they are too importunate, express your sentiments strongly." "How could any one but a fool be induced to take the burden from another's shoulders to his own by doing a crimson crime ; to violate both his conscience and the law ; to risk exposure, social and professional ruin, and the penitentiary, by putting himself into any one's guilty power, whether as a favor or for a paltry fee ?"

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## CONCENTRATED FOOD IN THE TREATMENT OF PULMONARY CONSUMPTION.

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ABSTRACT OF A LECTURE DELIVERED AT THE PHILADELPHIA  
POLYCLINIC.

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By THOMAS J. MAYS, M. D.,  
Professor of Diseases of the Chest in the Philadelphia Polyclinic and Visiting  
Physician to the Rush Hospital for Consumption, of Philadelphia.

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Calling attention to the importance of nourishing diet in the treatment of pulmonary consumption is so trite that it barely deserves repetition; yet old as it is, it is no less true to-day than

it ever was. Indeed it may be laid down as a fundamental proposition that the cases of consumption which cannot be reached through the instrumentality of food have certainly slim prospects of recovery. It is, also, no less true on the other hand that if your patient can be made to partake of, digest and assimilate a sufficient amount of food, it matters little in what condition his lungs may be, he will, with ordinary good management, make a good recovery in the great majority of instances. Failure to get well under these circumstances is the exception. To make your patient eat, then, is the great problem to solve in the cure of this disease, yet every one realizes the enormous difficulties which are constantly placing themselves in your way. Very little can be done to attain this end by only addressing medicines to the stomach. You are required to rise higher than this, and to take a general survey of the whole condition of your patient. In other words, it is absolutely indispensable that you should regulate his exercise, his rest, his sleep, and his eating, in fact you must have a systematic supervision of all he does during the whole twenty-four hours. I have arrived at the conclusion long ago that a consumptive patient who is fatigued, cannot eat. So his appetite will greatly depend on how much, or how little exercise you prescribe for him. If much exercise tires, then less must be taken, and if little exercise tires, then absolute rest must be insisted on. Many of these poor people exercise themselves to death. Digestion, like exercise, requires a certain degree of bodily strength. The strength which is expended in performing exercise, deducts so much from the sum total of the bodily forces, and in most cases leaves too small a residuum to carry on the processes of digestion, absorption, and assimilation, and is the principal cause of the persistent anorexia. I am well aware of the prevalent impression that exercise is one of the essential promoters of a good appetite, but all you need to do is to ask your patient to give you an opportunity to demonstrate the falsity of this belief by a prolonged dose of rest, and I dare say that a single chance will be sufficient to dispel the illusion. Rest will not only restore his appetite and save his strength, but it will reduce his fever, diminish the cough, and make him feel more comfortable in every respect

If your patient eats, what kind of food should he have? It is that kind which concentrates a large amount of nutritive material in a small bulk, and which requires a small amount of digestive energy on the part of the stomach and the digestive tract. Such foods exist, without question, in the freshly prepared juice of beef, oysters and clams, and they are prepared as follows: Beef, preferably the round steak, is cut in pieces of the size of a walnut, and is placed in a pan and held over the fire for a few minutes in order to heat the outside slightly. The whole is then dumped into a large Bartlett beef-press, and this separates the juice from the fibre. About one-and-a-half pounds of beef will yield a teacupful of beef juice. This juice, divested of all fat, is well seasoned and taken cold in half-teacupful doses three or four times a day. In the case of oyster and clam juice, the same process is followed in extraction, and it is likewise taken cold and seasoned. These juices contain the very essence of nourishment, require very little or no digestion, and are easily absorbed and assimilated, and may be administered to the most fastidious stomachs. They are very much superior to any kind of beef-tea, or extract, that can be made. Additionally I prescribe five or six glasses of milk a day. Much may be done in feeding these patients by going about it in a systematic manner. Begin at 7 o'clock in the morning with a glass of milk, and repeat the same every three hours. If a whole glass is too much, be satisfied if only half a glass is taken at first. At 8 o'clock administer half a teacupful of beef-juice. At first this is given three times only, but as soon as possible four times a day. If desirable, oyster or clam juice may be substituted once during the day for the beef-juice. Besides, you must persuade your patient to eat an egg, or oatmeal gruel, with cream and sugar, and bread and butter, and a cup of coffee for breakfast, beef-steak, roast-beef, mutton or lamb, with vegetables for dinner, and a lighter meal for supper. Beer, wine, champagne, whiskey, or brandy, may also be taken in moderate quantities throughout the day.

Much can be done to stimulate the appetite. For this purpose, I often give the following: R. Acid phosphoric dil.; acid nitromuriatic dil.; acid sulphuric aromatic; tinct. ferri chloridi aa fl.

3ss. M. Sig.: Thirty drops in half a glass of cold, sweetened water during meals. A coated tongue, which so frequently exists in these cases, is no contraindication to the giving of iron. Additionally two or three grains of quinine are prescribed in the forenoon and in the afternoon. The bowels must, also, be kept regular. If constipated, a glass of Hunyadi water, or a Lady Webster's pill in the evening will generally suffice. Topliff's Pavara pills, or Parke, Davis & Co.'s cascara cordial also serve well for this purpose. Occasionally a blue mass pill will not be out of place. If there is a tendency to diarrhœa, the above-mentioned acid preparation will often check it. In most instances of this kind the diarrhœa follows a meal, and is due more to a hyper-sensitiveness of the alimentary tract than to any other cause. To the acid mixture you may, therefore, add subnitrate of bismuth and pepsin with advantage.

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## ONE HUNDRED CONSECUTIVE CASES OF SKIN DISEASE.

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### VII.

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By M. B. HUTCHINS, M. D.,

Lecturer on Diseases of the Skin, Atlanta Medical College, Atlanta, Ga.

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#### TRICHOPHYTOSIS. (RINGWORM.)

Of the various forms of trichophytosis, or ringworm, of the skin there were six cases. Three of these belonged to the class "eczema marginatum," as formerly called, or *tinea cruris*. Began in scroto-femoral region spreading with "circular" (border concave towards origin, convex towards healthy skin) to thighs, along perineum to buttocks, or slightly over scrotum and pubic region. Left slightly scaly and brownish track behind. The border, usually well defined, raised, about one-eighth of an inch wide, papulo-vesicular or "vesiculo-squamous"—marked by presence of closely aggregated, more or less distinct, little

crusts. Occasionally a few typical lesions of ringworm as seen on the general skin (as the face or neck) external to the border of the principal diseased surface. Patients complained of much itching at night. These cases were adults, this form of ringworm being the more common in grown people.

The other three were cases of ordinary ringworm of the skin. I believe the first of these uncertain as the case was not kept up with.

The second case (of lady, age twenty-nine) was very peculiar, but the diagnosis was sufficiently easy. On flexure of left wrist was a circular non-elevated "spot" the size of a dime, and touching this another about the diameter of a pea, borders broken at point of contact. Center "clear"—only slightly brownish; border well defined, and about one-tenth of an inch in width, of purplish color and seemingly a little depressed, as if deep in the skin. Irritation produced itching. Condition present fourteen months, having begun as "a pimple" which gradually spread, clearing in the center. The peculiar appearance, and absence of scaling, I attributed to the applications made by the patient and the liberal *washing* the patch received. The patch had almost disappeared when the patient left the city about ten days after beginning treatment.

This case illustrates the puzzling appearances one sees in skin disease modified by previous treatment, and it is always well to inquire what has been previously done for the case, as the local treatment may have so modified the condition that it is unrecognizable through descriptions in the books.

Third case was simple and typical. Patient, a little girl of seven. Forehead, face, axillæ and left wrist affected. Began as small scaly "spots" soon forming the typical rings, with which, I think, every physician is familiar. The little girl probably "caught it" at school, and a little brother and sister very soon also became affected.

In the treatment of ringworm I have found the prescription below very effective, convenient and satisfactory:

R. Acid pyrogall., gr. xv.

Collodii., ʒi.

M. Sig.—Paint on and let dry, p. r. n.

An explanation of its action might appear purely theoretical, and, as these papers are intended to be only practical, I shall not enter into the theory of action of this prescription. The application frequently produces considerable irritation and may aggravate the itching, but under its use the typical lesions rapidly disappear. As the slightest remains of the fungus which produces the disease will cause it to relapse, no case should be left alone until there is absolutely no appearance of activity in the skin lesions, or until there is nothing left save a faint staining. If this rule is not followed you may hear months later that the disease kept relapsing "*and it must be in the blood.*"

#### IMPETIGO CONTAGIOSA.

It seems to me that Crocker, the English dermatologist, is right in his belief that the two usually described impetigos, and ecthyma should all come under the above heading. He attributes them to "pus infection," or, perhaps, to some not yet isolated micro-organism, producing pus. Thus, for example, I may mention the case of the young man reported to the Atlanta Society of Medicine last year (and report published in this Journal). The pustular lesions on the face were believed to have resulted from infection from a boil on the back of the neck. He recovered rapidly under cleanly and antiseptic treatment. General characteristics of these "impetiginous eruptions" were as follows:

Some cases showed pustules averaging the size of a pea, with red areola, sometimes a circle of raised epidermis, from serous exudation, between areola and base of pustule; some older were crusted, the crust of yellowish brown color, superficial and easily removed. Other lesions were large, crusted, superficial, with red areola—ecthyma. As a rule single lesions formed rapidly, and in some cases were deep enough to produce faint scarring, but usually only slight pigmentation remained and this soon disappeared.

Favorite localization was on the face, hands, feet and buttocks, or it might be even more diffused. Opening the pustules imme-

diately and the use of some one of the antiseptics, in "mild strength," as in the following, proved entirely efficacious:

R. Ichthyol,  
Zn. ox.,  
Calamin. prep., aa ʒi.  
Aquaë, ʒiv.

M. Sig. Apply frequently.

The number of these cases was five. Some had definite history of contagion, others doubtful. The localization, absence of grouping, and the symptoms given above sufficed for the diagnosis.

#### VITILIGO.

Of vitiligo, leucoderma or spotted (white) skin two cases were recorded. This is the disease producing the peculiar spotting of the skin in negroes who are sometimes exhibited in museums as "spotted people" or "negroes turning white." The two cases recorded were of white men, the first with a few small white spots beneath the jaw and quite large patches of non-pigmented skin on scrotum and penis. The other man had patches from reddish to clear white on face, neck and hands bordered by apparently deeper than normal pigmentation. This patient thought the trouble resulted from severe fright some fourteen years ago. Though only thirty-four he was as gray haired as a man of fifty; patient says it began to turn gray two weeks after the accident in which he was frightened and a limb broken. Prognosis in both cases was very discouraging. Attempt was made to "bring back" some of the pigment by the inflammatory action of cantharidal collodion, but the treatment was not persisted in. Perhaps the only thing to do in these cases is to devise something which will hide the white spots or make them nearly resemble the normal skin.

#### PSORIASIS.

There were two cases of this disease. First, vigorous young lady of seventeen. On legs below knees a number of roundish or circular, well-defined, circumscribed patches, with adherent scales, patches having parchment-like feel. On knees, elbows

(favorite location), and forearms, a few fingernail-sized spots covered with dry, "silvery" scales, which being scraped off exposed the bleeding papillæ—"punctate hemorrhage"—quite characteristic of psoriasis.

Under R. Ac. salicyl., gr. xv.

Collodii flex., ʒi.

M.

painted on, the small lesions were "about well" in a week. After three months, recovered under scrubbing patches with *sapo viridis* and alcohol, followed by application of

R. Picis liq., ʒi.

Ether sulph.,

Sp. vin rect., aa ʒi.

M.

And taking "Fowler's solution" in dose gradually increased to tolerance. Relapse last August relieved in about ten days with same treatment.

Second case, that of a young doctor, who wrote a description of the case and sent some of the scales by mail. Diagnosis of psoriasis was made and treatment given, but I have not heard further from him. It is generally possible to remove the eruption of psoriasis, but an absolute cure is doubtful of attainment.

Epithelioma, ulcers, etc., next article.

1 ½ *Edgewood Avenue.*

ANTIPYRIN IN INFANTILE ENURESIS.—Dr. J. Bouisson (Theses de Lyon) states that the effect of antipyrin in the treatment of the enuresis nocturna of childhood is "simply marvelous." The remedy is exhibited in doses of ten grains, repeated to the third time (30 grains in all) at intervals of one hour, commencing four hours before bedtime. Of eight inveterate cases in which the disease had existed for several years, and upon which every other remedy and method of treatment had proved futile, every case was completely cured. Several months have elapsed since the treatment, and in no case has there been a relapse, nor have any symptoms of return been noted.—*Nat. Druggist.*



## Correspondence.

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### OUR NEW YORK LETTER.

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NEW YORK, July 15, 1891.

#### THE UNIVERSITY.

The Fifty-first Annual Announcement of the Medical Department of the University, which has recently appeared, is particularly interesting from the fact that it heralds a change in the management and curriculum which is of great importance to the advance of medical education in America. This becomes more apparent when it is stated that 6,033 matriculates have been awarded the degree of Doctor of Medicine by the University, since the department was established, 203 of whom graduated at the last commencement. By the new arrangement, the pecuniary interests of the college are placed in the hands of a Board of Trustees, by whom the professors and tutors are paid stated salaries, which are entirely independent of the number of students who matriculate or graduate. A three years' course of study at the college has now been made compulsory instead of optional, as formerly. A still more important change, however, is the subordination of didactic lectures to recitations, and laboratory and clinical work, in the first and second years. The first year's curriculum consists of recitations in anatomy, chemistry, physiology, and pathology, with dissection, and laboratory work in chemistry, materia medica and histology. In the second year lectures are given in experimental chemistry, physics and hygiene, experimental physiology, surgical and regional anatomy, and materia medica ; and recitations are begun in medicine, surgery and obstetrics. Six hours daily for two months of this

year are spent by the student in the pathological laboratory, and he attends medical and surgical clinics.

Thus the whole course is gone over in recitations, and a thorough groundwork is given in the principles underlying the art of medicine, before the student listens to a didactic lecture on the more practical subjects of the course.

In the third year, however, lectures are given in medicine, surgery and obstetrics, and in gynæcology, therapeutics and pathology. General and special clinics are also given to the class as a whole, while sections of about twenty-five are given daily instruction at the bedside in Bellevue Hospital, where opportunities are offered for observations of the progress of diseases, and the effects of remedies.

Another good feature of the course consists of an arrangement to insure the attendance of each student upon a number of obstetric cases before his graduation. This does away with the former custom of authorizing men to attend women in confinement before they had made a vaginal examination of a parturient woman, or were in any degree practically familiar with the most ordinary duties devolving upon them as accoucheurs.

The University now offers, I believe, the best course of study of any college in New York, and the fine equipment of all the laboratories, and the abundance of clinical material here, would lead one to believe that no better is at present offered in this country.

#### A MEDICO-LEGAL POINT.

A murder trial which has just been completed in this city is of some-interest to medical men, from the fact that the expert medical evidence was largely instrumental in deciding the verdict. The facts of the case were somewhat as follows : During the night of April 23d, of this year, an abandoned woman known as "Shakespeare" was found dead and mutilated in a room in a vile resort called the East River Hotel. It was apparent that she had been murdered, and the mutilation of the body suggested the possibility of the murderer being "Jack the Ripper," of Whitechapel notoriety. The body of the murdered woman was

found on the bed, with a blood-stained shawl and petticoat wrapped around the head. The lower part of the abdomen had been opened and a portion of the ileum and one ovary cut out. A blood stained knife was found near the body, and the ticking of the bed was soaked in blood. It was also discovered that there were blood stains on the floor in the hall, and bloody finger-marks were seen by the side of the door of the room opposite that in which the body was found, and inside the door on the wall. There was, also, a spot of blood as large as a dollar on the bed in this room.

It was learned that "Shakespeare" had gone to the room in which she was murdered accompanied by a man, who disappeared during the night, and has not been heard of since. The opposite room had been occupied by a man, an Algerian by birth, known as "Frenchy." This man, "Frenchy," was arrested near the hotel the night after the murder. His socks were stained with blood, as were, also, the front flap and sleeves of his shirt. His nails were very long, and four days after his arrest the matter beneath them was removed and preserved for examination.

It was stated at the trial that the murdered woman had eaten corned-beef and cabbage during the day of April 23. Microscopical examination of the various blood stains and of the matter taken from beneath the prisoner's nails was made by Dr. Henry F. Formad of the University of Pennsylvania, Dr. Cyrus Edson of the Health Department of this city, and Dr. Austin Flint. On the strength of their discoveries it was declared that the blood on "Frenchy's" clothing was mixed with the contents of the small intestine. All the evidence against the prisoner being circumstantial, this became a very important point, especially as all the other witnesses except the experts were degraded characters, whose words were untrustworthy.

It was stated by the experts that the blood stains examined were of mammalian blood. In the specimens from the back of the prisoner's shirt, from one sleeve, from the floor of the hall, and from the ticking of the woman's bed, her stockings and petticoat, only blood was found. In the matters from under the pris-

oners nails, the front flap and right sleeve of his shirt, and from the wall-paper of the hall, the blood of the door and casing, the socks of the prisoner, and the bedding of the room which he occupied, blood was found mixed with biliary coloring matter unchanged; fat globules and crystals, tyrosine, cholesterin, triple phosphates columnar epithelium, eggs of round worms, starch granules, partially digested muscular tissue, and vegetable matters.

In an article in the last number of the *New York Medical Journal*, Dr. Flint states that, in the specimens examined by him, the most prominent features were in addition to the blood, the sheaves of crystals of tyrosine, columnar epithelium stained with bile, the partially digested muscular tissue, and a very few muscular fibres nearly perfect in structure, with the hard residue of spiral and other vegetable cells. The presence of tyrosine, of bilirubin, and the very slightly altered muscular fibres led him to the belief that the matters were from the small intestine.

He testified to this effect, and that the specimens presented practically the same appearance. He did not believe that the contents of the large intestine (fæces) would show tyrosine or bilirubin. Dr. Formad gave a similar opinion, and stated emphatically that he would be willing to stake his life on its soundness.

On these grounds and that the large intestine of the woman had not been injured, the jury were convinced that the prisoner was guilty, and brought in a verdict of murder in the second degree. This is one of the most remarkable trials that has ever been held here, and the medical testimony has provoked much discussion.

#### INDIGESTION A CAUSE OF INSOMNIA.

This is the subject of an editorial in a recent number of the *Boston Medical and Surgical Journal*. It is stated that in practice among children, the physician invariably seeks for some disturbance of digestion when insomnia is complained of. In certain persons, too, it is well known that to eat even a moderate meal late in the evening means a sleepless night. The flatulence pro-

duced by indigestion distends the stomach which presses on the thoracic organs and causes disagreeable sensations and palpitations. Toxic products are also formed which irritate the nerve centres and render the cerebrum hyperæmic.

Persons with healthy stomachs and normal arterial tone on the other hand, find that sleep is not in the least disturbed by the process of digestion. In fact many of them sleep readily and comfortably after a full meal. It is denied that the digestive functions are practically suspended during sleep, as is claimed by some authorities. The functions of the stomach and intestines are continued during sleep though with lessened activity; the secretions are not suspended, and the unstriped muscular fibres continue to act, though sluggishly. In fact, all the essential functions, such as circulation, respiration, digestion, etc., continue to be exercised during sleep but not so actively.

Most cases of digestive insomnia are due to difficulties attending the secondary or intestinal digestion. The patient goes to bed at the usual hour, but is unable to sleep for hours. The wakeful period corresponds with the time of pancreatico-intestinal digestion of his last meal, and when the process is completed he goes to sleep. That this is true can be proved by having him eat only a very light supper, or eat nothing after four o'clock, when he will go to sleep at the usual time.

The treatment of these cases requires careful attention to the quality and quantity of the food. Errors as to quantity are most frequent and must be avoided. Proper cooking is an important matter, and a judicious selection of meat that is juicy and tender. Men of sedentary habits, "brain-workers," constitute the largest proportion of sleepless patients, and it is very important to them especially that food should not be difficult of digestion. The laborer working his muscles in the open air needs foods that digest slowly, and his sleep is not disturbed in the slightest degree by boiled beef and cabbage, pork and beans or mince-pie. Not so with the man of sedentary habits, however, who should avoid or eat but sparingly of food known to be difficult of digestion.

Physical exercise, a cold bath every morning, change of scene

and diversions, and the cultivation of a contented, cheerful frame of mind are important points in the treatment of many cases.

Among medicinal agents, alkalies before meals, and acids and pepsin after, have been found valuable. Small doses of strychnine are useful. Professor Germain Sée advises sufferers from acid dyspepsia to take a drachm of bicarbonate of soda in hot water at bedtime. Constipation is usually present, and requires such laxatives as rhubarb, Glauber salts, cascara, enemata of hot water, etc. The last mentioned often proves a sovereign remedy for insomnia. When there is a torpid liver, euonymin, podophyllin, or blue pill is indicated.

WM. L. RUSSELL.

151 East 50th Street.

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### LONDON LETTER.

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LONDON, ENGLAND, May, 1891.

*Editors Atlanta Medical and Surgical Journal :*

I left New York, April 30th, on the Augusta Victoria, with a first cabin passenger list of 200 people. It may be that a few notes by the way will be of interest to you.

Living in Thomasville, where so many come each year, from colder climates, either for pulmonary or other diseases of the respiratory mucous membranes, or simply to escape the rigors of a northern winter, and who coop themselves so closely (except the very brightest and the warmer days) in a warm, close and superheated hotel, and who avoid a draught of air, or a wind, and growl and stay in doors on a day the least cloudy or damp, the freedom with which the deck was used as a promenade, sitting or asleep, where it was damp—even wet, warm or cold, cloudy or fair, a rushing wind or a gentle breeze, day or night, fixed my attention very strongly. But it only made me more determined to make my patients with all forms of diseases of the respiratory mucous membranes, and other chronic ailments too, for that matter, follow more fully my advice to remain much in the open air. It is this prescription that has been most diffi-

cult for me to have carried out, because of the general and firm belief, that a wind or an atmosphere damp, as upon a rainy or cloudy day, was of great harm and would be the cause of "catching cold."

In the eight days of voyage, the neurasthenic became more composed, the dyspeptic gained appetite and digestion, and some with slight cough lost it entirely.

This is all attributed to the sea air, and there is, perhaps, some difference in effects upon the system between the atmosphere of the sea and land, but it would seem that if the same life in the open air was led on land as on sea, the same good would follow. Invalids on sea, and at many watering places, improve not because of the mineral water or the sea air, but because of the more healthful manner of living.

In the treatment of pulmonary diseases, Dr. Trachenix, of Saranac Lake, N. Y., has his patient to remain in the open air so long each day, no matter what the weather. This seems to be the most important part of the treatment for this terrible disease, for there is no therapeutic agent more than slightly auxiliary to other treatment. The questions of altitude, humidity and temperature have not so important a bearing as a *pure* atmosphere. Of course, a moderately high temperature is better, is more comfortable, and it *invites* to outdoor sittings and adds desire and pleasure, which would not accompany in a cold and cloudy climate. Certainly, there is no need to say that one should be well wrapped and keep warm, as they do on the sea.

While touching here, incidentally, climate, the most important agent in the treatment of pulmonary consumption, one is impressed by the entire lack of the use or even mention of Koch's lymph, here in Edinboro. The first operation that I saw in London, was cutaneous lupus, by Mr. Clutten, of St. Thomas Hospital, who thoroughly scraped it in the usual way. There were other operations for tuberculous external manifestations, and Koch was not mentioned. In the case of a tuberculous or scrofulous child, an abscess in the lumbar region, due to disease in the vertebræ, was opened the second time. I say second time, because it is Mr. Clutten's method to curette out all tuberculous

and inflammatory tissue after incision and evacuation of pus, disinfect thoroughly and close the wound properly. He uses no drainage tube because there will be, he thinks, more or less infection by it, with the greatest care. He reopens the abscess should pus again form, and again closes wound as before. The drainage tube in such cases by most surgeons would be used, and, it would seem, to better advantage.

Mr. Croft, of St. Thomas, resected the articular ends of all the bones of the elbow joint in tuberculous bone disease and was extremely careful in preserving all of the muscular and ligamentous attachments, by keeping the knife well against the bone. This he explained as Mannder's operation, and expected to have a fairly good arm, and would later on begin passive motion.

On this subject of passive motion, after resections, Mr. Duncan, of the Royal Infirmary, Edinboro, made a long clinical talk, in which he said that in *reality* there was no "passive motion," and he made no effort in dressing such cases to prevent motion, as the patient would make but little any way, and if so was only what would be done by the surgeon, *actively*, later on. It was merely, after all, a difference in terms in relation to the motion by patient or in the abstract, but the point was to allow motion by the patient as freely as it wished, by not having the splint adjusted with the perfect rigidity that is usual.

In Edinboro, at the Royal Infirmary, completed in 1875 at a cost of one and one-half million dollars, there is much to be seen.

Mr. Annandale operated on a large, double adherent inguinal indirect hernia. One side, Mr. McEmon's method, of thoroughly tearing all adhesion of the sac and then folding it, as it were, by suture, and stitching in firmly to the borders of the ring; the other, the sac, after being freed from attachments, was cut off, and the stump stitched to the pillars of the ring, with the same sutures used in closing external wounds. Some operators use a separate suture for the peritoneum and the abdominal parietes, but from good results from either method, we would conclude that there was no difference in their value. In a case of strangulated hernia, of five days, in my own practice, after the return of the intestines into the abdominal cavity, there was a large mass of pro-



truding and irreducible omentum which I amputated well up to the ring and brought the cut edges together in the same manner as Mr. Annandale.

There was a good recovery. Mr. Annandale's assistant, in a case of obstruction of the bowels of seven days' duration, opened the abdomen but found no cause for the obstruction but a long, stringlike piece of peritoneum extending from an attachment over the diaphragm to the inguinal region. An ineffectual effort was made to produce a movement of the bowels by large injections of water. The result of operation I could not learn, as I left for London again the next day. Through the kindness of Dr. Battey, who gave me a letter of introduction to Dr. Simpson, I had the pleasure of accompanying the latter to a meeting of the Royal Obstetrical Society, but no paper of interest was read, though a short one by the President, Mr. Berry Hart, on a new nomenclature for presentations, based upon anatomical relations, elicited some discussion, the sense of which was that the present classification was better.

At King's College Hospital Sir Joseph Lister operated upon a case of fracture of the patella by suture with silver wire. There cannot be osseous union in this fracture, because, by muscular contraction, the planes of the fractured bone are almost at right angles to each other, and the periosteum and tissue above being put on the stretch before rupture to more than normal, when the fractured ends of the patella are approximated by any apparatus, this stretched and torn tissue drops over the fractured edge of the fragments and is a periostael and other tissue cushion between them and prevents necessarily other than ligamentous union, even though the apposition be otherwise perfect. This interposed tissue is most carefully cut away, so that only bone surfaces are in contact. This detail is important. The wire used is one-twentieth of an inch silver. A common bradawl is used for working the hole for suture, and begins about half an inch from the fracture, on the external surface of the patella, and is brought out just at the interior edge, just above the periosteum.

If the holes in the fragments should not be in perfect line, the bone above the lowest suture is picked away with the awl until

it is of the same height as the other. In tying the wire a half knot is made and the ends then bent across each other as a chain link, which prevents slipping and is not too large for the proper covering by the skin. A posterior splint is used, and passive motion, when the union of bone has been complete.

All of the London surgeons do not wire fractured patella, but content themselves with only a fairly useful limb from union by ligament, thinking the risk of an inflammation of the knee joint and its results too great to justify it, notably Mr. T. Holmes.

Yet Lister makes the operation and gets his good results. Mr. Holmes does not and has imperfect limbs.

Let each surgeon and each patient decide what will be done. Much depends upon the occupation of the patient as to whether the wiring treatment is imperative or not. It is always better. In the wards was a patient with dislocation of seventh cervical vertebra, for which Mr. Lister, a week before, had operated by wiring the spinous processes together to prevent displacement which takes place after reduction. There was almost complete paraplegia, in which there had been no improvement from the operation, and a fatal termination was feared because of the injury which occurs, in such cases to the spinal cord at the time of the accident and by the pressure of the dislocated vertebræ upon it. In future cases Mr. Lister proposed to remove the laminæ of the vertebra, as well as wire the spinous processes, so that should there be slight displacement the pressure upon the spinal cord would not exist.

Every one knows that Mr. Lister has discarded the spray in his operations, and in his lecture he said it was impossible to get any wound free from bacteria, for even in the laboratory one out of five of the sterilized tubes would have bacteria, which the experimenter regarded as a good percentage. He said that the human organism had a certain power to resist the action of bacteria, and this power was the aid to the surgeon in procuring non-suppurative wounds treated by as thorough an antisepsis as possible, in the operation. Practically this is but the "vital resistance" of pre-bacteric time, and the phagocyte and its opponent, of the present date. And while it is of little importance to enter

into a discussion of the comparative value of antiseptics (or their value at all) and asepsis in surgery, it would seem that Mr. Lister, in his clinical lecture, really acknowledged that thorough cleanliness was all that could be obtained in surgical wound treatment, and that antiseptics had but little to do with the good results in modern surgery, and of which Mr. Lister is the undoubted and justly acknowledged and celebrated author. In a short paper, "Cases in Surgery," which I presented to the Medical Association of Georgia, at Macon, in 1884, it was held that *perfect* cleanliness, such as would be given by an *abundant* and *thorough* use of warm water, perfect apposition and fixedness of wound surfaces, a dressing with an abundance of absorbent cotton to absorb secretion, maintain equable pressure and preserve a normal warmth of the wound, that the results would be as good as by the use of bichloride or carbolic acid solution. A short time before leaving home I amputated a leg, just below the knee of a negro injured by a railroad accident, cleansed well with soap and warm water, used no antiseptics on either sponges, ligatures or sutures, cut the ligatures close, closed the wound without drainage, dusted some iodoform over the wound, dressed with gauze and cotton, and in thirteen days redressed the wound for the first time. It had healed. There was no suppuration. The ligatures around the arteries (of silk) gave no trouble, and yet no antiseptic had ever touched them. But, as before said, so that hands, sponges, instruments and everything used in an operation be *clean*, it is of little importance, practically, whether antiseptics are of value or not, for the patient cares not whether he is cured with or without a particular agent, but the exact scientist desires to know which and what agent, or combination of agents, produces his results.

It may be of much interest to know that chloroform is almost exclusively used here and in Edinboro, and that it is simply poured in small quantities at a time upon a folded napkin or handkerchief.

Only twice have I seen ether used at all (with a modified Claven's apparatus) where a prolonged anæsthesia was necessary. To most American surgeons, at least, this may seem rather an

unwarranted risk in the choice of an anæsthetic, after the very able and interesting paper of Dr. Wood, of Philadelphia, read before the International Congress, in Berlin, in which he set forth as the result of experiment the greater effect of chloroform than ether in depressing and stopping the action of the heart, to lessen which he advised the administration of digitalis hypodermically just before beginning the anæsthetic (sometimes also, nux vomica) as a cordial, tonic or stimulant.

I will remain a few days in Paris, *en route* to Berlin and Vienna, and may send you a few notes from that place.

T. M. MCINTOSH, M. D.,  
of Thomasville, Ga.

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**TRANSMISSIBILITY OF SYPHILIS.**—As published in his magnificent atlas of *Venereal and Skin Diseases*, Prof. Morrow's conclusions in reference to the hereditary transmission of syphilis are :

1. A syphilitic man may beget a syphilitic child, the mother remaining exempt from all physical signs of the disease ; the transmissive power of the father, is, however, comparatively restricted.

2. A syphilitic woman may bring forth a syphilitic child, the father being perfectly healthy; the transmissive power of the mother is much more potent and pronounced, and of longer duration than that of the father. When both parents are syphilitic, or the mother alone, and the disease recently acquired, the infection of the fœtus is almost inevitable; the more recent the syphilis the greater the probability of infection, and the graver the manifestation in the offspring.

3. While hereditary transmission is more certain when the parental syphilis is in full activity of manifestation, it may also be effected during a period of latency, when no active symptoms are present.

4. Both parents may be healthy at the time of procreation, and the mother may contract syphilis during her pregnancy, and infect her child *in utero*. Contamination of the fœtus during pregnancy is not probable if the maternal infection takes place after the seventh month of pregnancy.—*Weekly Med. Review*.

## Editorial.

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### THE LEGISLATURE *vs.* THE PHYSICIAN.

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[The Lower House of Georgia's rural Legislature, in present session assembled, recently passed the following bill :

SECTION 1. *Be it enacted by the General Assembly of Georgia*, That from and after passage of this Act, no physician or prescription clerk in any drug establishment in the State shall be allowed to practice medicine or fill a prescription who may become drunk from use of either intoxicating liquor or opiates.

SEC. 2. *And be it further enacted*, That violation of the first section of this Act shall be a misdemeanor, and upon conviction shall be fined not less than two hundred dollars, nor more than five hundred dollars; and shall be liable for all damages to their patients or customers while practicing their profession or calling, while under the influence of intoxicants; and upon a second conviction of drunkenness shall forever forfeit their licenses, or the privilege under the laws of Georgia to practice medicine or fill prescriptions.

As we go to press this measure awaits the consideration of the Senate. The following communication has been received from a prominent physician in Atlanta. We commend it to our professional readers, and also to the thoughtful and prayerful contemplation of our rustic lawmakers.—L. B. G.]

You ask me what I think of this class legislation recently enacted by the Legislature of Georgia. It is iniquitous. Yes, it is iniquitous, officially to brand us physicians as a class especially addicted to the evil of intemperance to the exclusion of all other classes !

Every calling has its duties and responsibilities. Every man has a part to perform in this world, and whoever underrates his avocation forfeits his manhood. If a physician has great responsibilities involving life, property, etc., so has the railroad man, the navigator, the civil and mining engineer, the street-car driver,

the brick-layer, the electrician, the lawyer, the divine, the judge, all trades and professions, and last but not least, the *legislator* !

It would be interesting to compare the moral status of physicians with that of any other class of citizens. I think we would soon realize that comparisons are odious !

Our dealings are essentially with suffering humanity. Who does more charity than the physician ? Who does more for the honor, good name and protection of home and family than the physician ? Were we to betray the confidences that we are entrusted with, this world would be a field of carnage ! Who is oftener treated with ingratitude than the physician ?

To deprive a physician of his inalienable right to make a living because, forsooth, he has had the misfortune to get intoxicated, either by himself or with such a companion as a lawyer, a capitalist, a tramp, or perhaps a legislator, is a monstrosity !

A minister *may* have the misfortune of getting drunk. I think it will be conceded that this is not an impossibility. The church may or may not take cognizance of his offence. He may be deposed or he may be shielded by his flock. Is there a law to punish him or withdraw his license from him ?

A lawyer may go to a club dining, or to a noted banquet—he always manages to get an invitation—and he will go home full to the brim. Is there a law debarring him from the right of practicing law ?

A judge, the very incarnation of the majesty of the law, may, after having during a limited session sent a poor inebriate to the chaingang over and over again for the same offence and deprived his wife and children of his support, go and rest his worried brow in the shades of Tybee, Cumberland or St. Simon's, and there and then make up for lost time and opportunity, and silently but surely and unmistakably imbibe *usque ad nauseam*, whilst his friends are fishing or bathing on the seashore. Is

there any law to render his conduct odious in the eyes of his fellow-men and disgrace him by removing him from office ?

And what shall I say of our legislators themselves, entrusted with the interests of this great commonwealth ? Are they, as a class, above reproach ? If any one wishes to be enlightened and edified on this subject, let him visit the numerous bar-rooms of this city, and I will venture the assertion that for one doctor found or seen in front of the counter, he will find ten legislators. There are no less than two hundred physicians in Atlanta.

I will close by stating that the legislators have been for several years encircling their noble heads with a halo of glory. Their persons are inviolable, and the police are not permitted to arrest any of them. "*The necessity for a quorum demands it.*"

"*Ne touchez pas a la reine*"—Do not touch the queen, says the French. Do not arrest a drunken law-maker, says the Georgia enactment ; but *if a doctor gets drunk let him and his family starve !*

"It is not for kings, O Lemuel, it is not for kings to drink wine, nor for princes, strong drink. Lest they drink, and forget the law, and pervert the judgment of any of the afflicted."

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## IN MEMORY OF DR. JOS. P. LOGAN.

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Dr. Joseph Payne Logan was born in Botetourt county, Virginia, November, 1821, and died in Atlanta, Georgia, June, 1891. He was educated at Washington College, Lexington, Virginia, and studied medicine at the Virginia Medical College, Richmond, and the University of Pennsylvania, Philadelphia, graduating at the latter in 1841. He practiced medicine in Culpepper county, Va., until 1854, when he moved to Atlanta, Ga. In the latter part of 1861 he was commissioned as a surgeon in the Confederate service, which place he filled with distinction. At the close of

the war he resided in Baltimore, Md., and was Professor of the Principles of Medicine in the Washington University. He returned to Atlanta in 1868 and resumed permanent citizenship and practice there. He held many important trusts. He was in 1861 one of the two delegates appointed to urge the Confederate Congress to locate the Confederate Capital at Atlanta. He was an organizer and President, in 1871, of the Atlanta Academy of Medicine; Professor of Physiology in the Atlanta Medical College; a member and President of the Georgia Medical Association; Vice-President of the American Medical Association; appointed by the Governor member of the Georgia State Board of Health; author of reports on Small Pox and Yellow Fever in Savannah; member of the first Board to organize the Atlanta Public Schools, and for several years editor of the ATLANTA MEDICAL AND SURGICAL JOURNAL.

Dr. Logan was a great physician, a noble man and genuine Christian. Like the pastor, the doctor deals with the spirit, but unlike him, heals the body, mingling two sacred missions. Dr. Logan blended physical healing and Christian comforting in a marvellous degree. His sympathy was as gentle as his science was skilled. He had a remarkable patience and subtlety in reading ills and an extraordinary grasp of cure. He was a born doctor by mind and temperament. He had natural medical genius. His strong native intuitions in healing were fortified by the largest culture in medical science. He had a face and form that typified his noble nature. He was a strikingly handsome and imposing man of majestic proportions and carriage, and a head and countenance benignant and comely. He was a rare character, strong yet pure, manly and gentle, proud though tender, able but pious. He had an enormous practice in Atlanta, and it is doubtful if any of its citizens ever shared more widely in the sorrows of its good people, was ever linked more closely to its



sacred memories or will be more regretted than Dr. Logan. He was a pious member and efficient elder in the Central Presbyterian church. He was a wise and successful business man and the soul of integrity. He was full of charity and public spirit.

He married in 1843 Miss Ann E. Pannell, of Orange county, Va., who died April, 1885 ; and in June, 1887, Miss Alice Clark, of Atlanta, Ga. He leaves one granddaughter, Miss Laura Grant.

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THE Kentucky State Board of Health has recently adopted the following resolution:

*Resolved*, That the Secretary be instructed to place upon the list of Medical Colleges, whose diplomas are to be certified and endorsed for registration under the laws of this State, only such colleges as shall, after the session of 1891-92, exact of matriculates and graduates a minimum of requirements not less than those required by the American Medical Association.

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DR. FORDYCE BARKER, of New York City, died on May 30th, at the age of seventy-three. Dr. Barker was one of the ablest and most prominent of the New York profession. He had for many years occupied the Chair of Obstetrics in the Bellevue Hospital Medical College. He made several valuable contributions to medical literature, the best known of which is his classic treatise on Puerperal Diseases.

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DR. G. FRANK LYDSTON, of Chicago, has been elected Professor of Genito-Urinary and Venereal Diseases in the College of Physicians and Surgeons, Chicago.

## Selections.

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### ETHER OR CHLOROFORM ?

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Dr. Julliard, after narrating a case in which death occurred during etherization, gives 20 cases of death by chloroform, 17 of those being published for the first time. Of the 20, no fewer than 15 occurred before the operation had commenced. He then sums up his argument by stating : (1) that any one who is anæsthetized by chloroform or by ether risks his life ; and (2) that the risk is five times less with ether than with chloroform. If, then ether is less dangerous, why is it not preferred ? This leads Dr. Julliard to discuss the objections to ether, and his fairness is indicated by his careful consideration of no fewer than eighteen objections : (1) Ether is disagreeable. This is a matter of taste, and is hardly worthy of consideration, in view of the risk. (2) Ether is difficult to administer, requiring complicated apparatus. Dr. Julliard gives it with a very simple mask containing gauze and flannel, and covered with macintosh cloth. (3) Ether is less active than chloroform, and the anæsthetic effect is more slowly produced. True ; but the little delay is more than compensated by the additional safety. (4) Ether does not produce a sufficiently deep anæsthetic effect. Denied ; objection not consistent with experience, if a sufficient dose be given. (5) Stronger preliminary excitement with ether. Excitement occurs in about the same number of cases with both anæsthetics. Dr. Julliard finds that a preliminary subcutaneous injection of morphine in most cases prevents excitement. (6) Vomiting is more common after ether. Statistics show that this occurs in 1 in 9 cases after ether, and that the proportion is about the same after chloroform. (7) Ether is inflammable. True ; and therefore it should not be used where the thermo-cautery is to be employed

in operations on the head. As a matter of prudence, chloroform is to be then preferred. (8) Ether causes coughing during the operation. True; but this may be diminished by breathing at first through the nose a vapor not too concentrated, and by a subcutaneous injection of morphine. (9) Ether salivates. An exceptional phenomenon, occurring in 1 in 20 cases, and disappearing during deep anæsthesia. Where it is necessary to guard against it, a subcutaneous injection of morphine and atropine is efficacious. (10) Ether excites bronchial secretions. This occurs rarely, and the tendency is much diminished by the subcutaneous injection of morphine and by breathing diluted vapor. It occurs chiefly at the beginning of the administration, and disappears in deep anæsthesia. (11) Ether causes cyanosis. This occurs in nervous and alcoholic subjects. When observed, stop the administration, and recommence when the cyanosis has passed off. Cyanosis only occurs in cases in which any anæsthetic is more than usually dangerous. (12) Ether asphyxiates. This accident may occur in one of two ways: (a) by an arrest of the respiratory mechanism; or (b) by tracheo-bronchial hypersecretion. It is not common. Stoppage of administration and artificial respiration are the proper procedures. (13) Vapour of ether disagreeable to other patients, nurses, etc. This is largely avoided by using a proper mask. (14) Ether causes severe muscular tremors. This occurs rarely, chiefly in alcoholics, usually in the lower limbs, ceases during deep anæsthesia, and it may pass off on strong flexion of the great toe. It is very rarely seen after subcutaneous injection of morphine. (15) Ether is eliminated more slowly. It is true that patients recover more quickly from ether than from chloroform, but occasionally cases occur in which the recovery is not complete for several hours. These cases are very rare, and have no disagreeable conclusion. The rule is rapid recovery. (16) Ether lowers the temperature more than chloroform. This is also true, but the difference is so small as to be of no account. (17) Ether causes nephritis, pulmonary congestion, bronchitis, even pneumonia. Not admitted.

Dr. Julliard, in all operations of long duration, gives a subcu-

taneous injection of one-sixth to one-third of a grain of morphine. He finds that this calms the patient, notably diminishes the quantity of ether necessary, and sometimes produces, after a few whiffs of ether, a remarkable condition of analgesia, or insensibility to pain without loss of consciousness. The latter condition is undoubtedly the ideal anæsthetic state. The injection is given to the patient in a quiet room, and he is encouraged to close his eyes and to sleep. In about 20 minutes he is carried to the operating table, where in quietness and without excitement he is etherized. Julliard narrates 7 cases of analgesia with ether and 1 case with chloroform. In all these cases the patient was conscious but felt no pain, and in several he was able to aid the surgeon by voluntarily making convenient movements.

• In conclusion, Dr. Julliard denounces the method of giving a concentrated vapour of ether at the beginning of the inhalation, with the view of quickly producing anæsthesia, as being likely to cause any or several of the accidents of ether administration. He also views with disfavor Kocher's method of giving chloroform at the beginning, and of continuing the anæsthesia with ether, designating the method as the combination of the dangers of chloroform with the disadvantages of ether.—*The British Medical Journal for April.*

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**THE NECESSITY FOR IMMEDIATE SURGICAL INTERVENTION IN LACERATIONS OF THE PERINEUM.**—The misfortune which has just happened to an unfortunate practitioner, who was mulcted damages to the amount of nine hundred dollars and costs by the Superior Court for neglecting a lacerated perineum, should be a lesson to every accoucheur in this country. It was shown that the laceration was complete, extending into the rectum, and had been followed by procidentia of the uterus and other distressing accidents.

The duty of attending to all extensive lacerations of the perineum at the time when the lesions are fresh is insisted upon by the best obstetrical writers, and it is certainly the practice of the most successful obstetricians in this country to immediately put

in three or more deep stitches, thus approximating and keeping in apposition the lacerated parts till union takes place. It matters little what material is used for the sutures ; some use chromacized catgut, and make a deep continuous suture, and certainly catgut has in many instances proved to be sufficiently enduring ; others prefer silk, others silver wire. Every physician has, or ought to have in his pocket-surgical-case ligatures and curved needles, and if a sufficiency of interrupted sutures are inserted immediately after confinement, the old-fashioned quilt suture may well be dispensed with. It will not always be necessary to give the patient ether in order to insert the stitches, though some nervous and susceptible subjects may require it. It is true that after a long and difficult confinement case, the medical attendant is generally tired out and shrinks from another operation, especially where anæsthesia is required, but he must muster strength and nerve for the occasion if he would escape liability to a suit for malpractice ; and if he inserts a few stitches he will save himself from the imputation of ignorance or carelessness. Modern juries have not the name of being very tender to the feelings, reputation or pockets of physicians, and it goes without saying that the most vigilant and attentive will be the least likely to be "caught napping."

There are one or two errors that should be cleared away, lest they should be subterfuges for the careless. The one is that tying the knees of the patient together will answer the same end as sutures. "Only a very credulous person," says Lusk, "really believes that he has witnessed union by first intention in extensive ruptures as the result of tying the knees together, and enjoining rest upon the side. The action of the transversi-perinei muscles tends to draw the torn surface apart. Moreover, the necessity of separating the knees in passing urine, and to enable the nurse to clean the genitalia, makes it impossible to keep them in contact for any lengthened period."

The other mistaken notion is that primary perineorrhaphy rarely succeeds, "that the perineum is not merely torn but is contused and mangled and that the previously œdematous and infiltrated tissues are predisposed to gangrene, and consequently are

in the worse possible condition for immediate union." (Charpentier.) Moreover, it is said that the lochial discharge will always be an obstacle to union by first intention.

According to the experience of very many who have tried the immediate operation, and who have seldom or never failed to obtain good union, if due pains toward cleanliness and antisepsis are taken, no such unfavorable result as Charpentier points out need ever be feared. Certainly, Charpentier's American editor warmly favors the immediate repair of any laceration beyond the first degree, for the reason that thus a possible entrance site for septic matter is prevented, and also because the operation is a simple affair after delivery, and more extensive and complicated, the longer we wait. He recommends that in case of laceration to the second degree only one deep silk or wire suture should be used; if the rent be deeper, three to five will be needed. In any event the patient should be placed on her side, a wad of absorbent cotton inserted into the vagina to catch the discharges, the wound carefully washed and trimmed of jagged shreds, and then, guided by the finger in the rectum, the suture is passed deeply around, at one-half inch from the margins. The line of suture should be dusted with iodoform, and a narrow strip of cotton laid along the perineum and the posterior vaginal wall. The after-treatment will consist in dusting with iodoform twice daily, and replacing the strip of cotton by a fresh piece till the six or seventh day, when the sutures may be removed.—*Boston Medical and Surgical Journal for May*.

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TREATMENT OF MALIGNANT NEOPLASMS NOT AMENABLE TO OPERATION.—Prof. v. Mosetig-Moorhof, of Vienna, states (*Wiener Med. Presse* 6, '91, as quoted by *Pittsburg Med. Rev.*, May, 1891) that he had employed all recommended remedies for years without noteworthy result. But he kept in mind that the pathogenic cell-elements possess decidedly inferior biological potency to the healthy tissue elements—pointing to the possibility of making active warfare upon the neoplasm without affecting the surrounding healthy tissue. Proliferation of the pathological

cell-elements, upon which the growth of the neoplasm depends, occurs from the nucleus of the mass. Hence, Mosetig thought, to concentrate treatment upon the proliferating nucleus would arrest the process, and even induce retrograde metamorphosis. This led him to stain the neoplastic tissue—an easy task—by filling it with aniline dye freed from arsenic. His first experimental case was a man, age 50, with an orange-sized, *round-cell sarcoma, in the inguinal region*, which several prominent Vienna surgeons pronounced unfit for operation. Mosetig injected one gram of a one per cent. solution of *aniline trichlorate* into the sarcomatous mass. After eight weeks treatment, the tumor diminished to size of a hickory-nut, with a healthy cicatrix at the site of the ulcer, and the patient was discharged decidedly improved. A year later, the man died of pneumonia, *without even a sign of recurrence* of the growth. Mosetig employed aniline trichlorate in three other cases, but was obliged to discontinue its use because of unpleasant effect in other directions.

A year ago, two new dyes—*methyl-violet* and *pyoktanin*—were introduced, and said to be perfectly harmless by Prof. Still-ing. Mosetig selected a lady, age 60, with a *sarcoma of inferior maxilla*, size of a fist, filling the oral cavity, and forcing the tongue up against the hard palate, so that she could neither speak nor swallow. The growth was injected with methyl-violet solution 1:500, which was increased to 1:300. In all, 35 injections were given of from 3 to 6 grams of solution at each sitting. Then the growth had shruken so that only a portion of the interosseous enlargement remained, and the patient was free of suffering. Up to this writing, no malignant disposition is manifest.

Five other cases—*cysto-sarcoma of sterno-clavicular joint*, *papilloma of urinary bladder*, *sarcoma of peritoneum*, and two *carcinomata of cervical glands*—have all done equally well with methyl-violet injections—all being decidedly improved, with possible absolute cure in the near future. Tumors not suppurating do not degenerate, but simply shrink together in retrogressive metamorphosis; while such as are ulcerated and discharging pus

for a time suppurate more freely, after which, with some diminution in size, they cicatrize rapidly.

The injections are repeated every two or three days, and made under strict aseptic precautions. Thus far, Mosetig has employed solutions of the strength of 1:1000, 1:500, 1:300; and he is of opinion that much stronger solutions may be used without danger.—*Va. Med. Monthly.*

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THE COLITIS OF INFANTS.—Dr. James M. French, in his valuable contribution (*Journal of the American Medical Association*), gives the following dietetic and medicinal treatment for colitis of infants: The child must receive the proper quantity of the right kind of food at the right intervals for its age. Not seldom the error will be found to consist in the too early resort to a mixed diet, too frequent nursing, or the use of such inferior substitutes for mother's milk as impure cow's milk, condensed milk, or an inferior quality of artificial food, or the use of improperly prepared food. The diet should consist of articles of food which are most certain to undergo easy and complete digestion, leaving as little residue as possible. The passage of healthy fæces from the small intestine into the larger in these cases is sufficient to excite peristalsis. For this reason overfeeding must be guarded against.

Ordinarily, the diet of nursing infants may be restricted to the mother's milk, and that of infants that have been weaned, to sterilized cow's milk. In severe cases, however, it is necessary to discontinue even cow's milk for a time. By this means the inflamed bowel is freed from the influences which keep up the inflammation. Something must be given both to provide nourishment and to satisfy thirst; for this the author highly indorses Mellin's Food, prepared with *water instead of milk*, as it furnishes ample nutriment and leaves almost no residue in the bowel. In addition to this, an occasional teaspoonful of freshly expressed beef juice and a few drops of brandy may be given.



The writer rarely employs any medicines other than those contained in the following prescriptions :

R. Pepsinæ (F. & F.), gr. xii to xxiv.

Hydrarg. chlor. mit., gr. ss to j.

Sacch. lactis., q. s.

M. et ft. chart. No., xii.

SIG.—One powder every three hours after nursing.

R. Ex. Pancreatis (F. & F.), 3ss to j.

Hydrarg. chlor. mit., gr. ss to j.

Sacch. lactis, q. s.

M. et ft. chart., No. xii.

SIG.—One powder every three hours immediately before or after nursing.—*Annals of Gynecology and Pediatrics*.

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ARISTOL.—Aristol (the bichloride of dithymol) is rapidly coming into favor as an excellent substitute for iodoform. It possesses all the therapeutic properties of iodoform without having the inconveniences of its irritant and poisonous action. It is a reddish-brown amorphous powder, becoming more and more pale as it loses its iodine from exposure to heat or light. It is soluble in water or glycerine, slightly so in alcohol, and very soluble in ether, chloroform and liquid vaseline. The powdered aristol has already rendered great service as a cicatrizing agent in ulceration of the skin and mucous membranes, in epitheliomata, in ulcers of the leg, and in tuberculosis and syphilitic ulcerations. Its application to these ulcerations is not painful, nor does it produce any of the phenomena of general poisoning, as does iodoform. Under the form of a pomade containing from ten to twenty parts of aristol to one hundred of vaseline, it has been used in cutaneous diseases, such as psoriasis, eczema, lupus, etc. Some observers have employed it in diseases of the nose, throat and larynx, and it has been used in gynæcological practice in the treatment of endometritis, erosions of the cervix, and vulvar eczema. Swieciki has made pencils and suppositories thus:

R. Aristol. ....grs., 80.

Gum Arabic, a sufficient quantity to make five pencils. And

- R. Aristol ..... grs.,  $7\frac{1}{2}$  to 15.  
 Ol. theobrom., sufficient to make one vaginal suppository.

It may be used in ethereal solution, or in collodion if so desired.

Internally it has been given in pill form associated with the hypophosphite of sodium in cases of fœtid bronchitis and gangrene of the lung, with excellent results. In four or five days the sputa loose their offensive odor and the general condition is greatly improved. In pulmonary phthisis it diminishes the amount of expectoration.—*Huchard, in Revue Gen. de Clin. et de Therapeutique, January 14, 1891.*

CHLORALAMID AS A HYPNOTIC.—Dr. G. Generisch has prescribed chloralamid in 32 cases, giving 30 grains at night. This dose was generally sufficient to induce sleep within half an hour. A more certain effect and a longer sleep was obtained when 45 or 60 grains were prescribed. He considers chloralamid preferable to other hypnotics, both because it acts more decidedly and because it is less unpleasant to take. It must be remembered that its effect is negative when sleeplessness is due to pain. It is not by any means a dangerous drug, but headache and vomiting may occur after a very large dose. It does not seem to affect the digestion nor the renal functions. The pulse generally becomes softer and more frequent.—*Med. Rec.*

TREATMENT OF INFANTILE ECZEMA CAPITIS.—Correct the acidity of the stomach by alkalies, and a properly regulated diet. A powder consisting of two grains each of calomel and bicarbonate of soda may be given about every other day; or a little Rochelle salts may be added. After the crusts have been removed by the local application of vaseline the following ointment should be constantly applied:

- R. Camphor, gr. x.  
 Calomel,  
 Goulard's Extract, } aa. ʒi.  
 Vaseline, ʒi.

—*R. W. Taylor, M. D., Medical News.*

**AVOIDANCE OF STIMULANTS DURING HEMORRHAGE.**—It is customary, when the accident of hemorrhage occurs, for the operator, or some bystander, to administer wine, brandy, or some other alcoholic stimulant to the patient, under the false idea of sustaining the vital power. It is my solemn duty to protest against this practice on the strictest and purest scientific grounds. The action of alcohol, under such circumstances, is injurious all round. It excites the patient, and renders him or her nervous and restless. It relaxes the arteries, and favors the escape of blood through the divided structures. Entering the circulation in a diluted state, it acts after the manner of a salt in destroying the coagulating quality of the blood; and above all other mischiefs, it increases the action of the heart, stimulating it to throw out more blood through the divided vessels. These are all serious mischiefs, but the last named is the worst. In hemorrhage the very keystone of success lies so much in quietness of the circulation that actual failure of the heart, up to faintness, is an advantage, for it brings the blood at the bleeding point to a standstill, enables it to clot firmly, when it has that tendency, and forms the most effective possible check upon the flow from the vessels. (The author refers to a case in which three pounds of blood was lost and the patient was unconscious, but which recovered. He refers to this case as typical, because, if a stimulant were not wanted in it, a stimulant cannot be called for in examples less severe.) The course followed was simply to lay the patient quite recumbent when signs of faintness supervened, and, so long as he could swallow, to feed him with warm milk and water freely. Such, in my opinion, is the proper treatment to be employed in every instance of syncope from loss of blood.

—*The Asclepiad, Dietetic Gazette.*

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FIFTEENTH ANNUAL MEETING OF THE AMERICAN DERMATOLOGICAL ASSOCIATION, TO BE HELD AT THE SHOREHAM HOTEL, WASHINGTON, D. C., SEPTEMBER 22d, 23d 24th AND 25th, 1891.—*Officers for 1891:* President—F. B. Greenough, M. D., of Boston; Vice-President—L. N. Denslow, M. D., of

St. Paul; Secretary and Treasurer—George Thomas Jackson, M. D., of New York. *Programme of Papers*: 1. Dermatitis Hæmostatica—Dr. H. G. Klotz. 2. A case of Lupus Erythematosus with fatal complications—Dr. W. A. Hardaway. 3. Report of a case of Universal Erythema Multiforme, with colored portrait and specimen—Dr. L. A. Duhring. 4. An unusual case of Sarcoma involving the skin of the arm, amputation, recovery—Dr. F. J. Shepherd. 5. Multiple Sarcomata. History of a case showing modification, and amelioration of symptoms with large doses of arsenic—Dr. S. Sherwell. *Discussion on Tuberculosis of the Skin*: 6. Its Clinical aspects and relations—Dr. J. C. White. 7. Its Pathology—Dr. J. T. Brown. 8. Its Treatment—Dr. G. H. Fox. 9. Thirteen cases of Tuberculosis of the skin, with their treatment—Dr. J. S. Howe. 10. A case of Lichen Scrofulosorum—Dr. J. Grindon. 11. Notes of a visit to the Leper Hospital at San Remo, Italy, with photographs—Dr. L. A. Duhring. 12. The treatment of Alopecia Areata—Dr. P. A. Morrow. 13. A Therapeutic note on Alopecia. Areata—Dr. L. D. Bulkley. 14. Morphœa Atrophica of Wilson—Dr. R. W. Taylor. 15. The treatment of Pruritus—Dr. E. B. Bronson. 16. Prairie Itch—Dr. L. N. Denslow. 17. Diseases of the skin associated with derangements of the nervous system—Dr. W. T. Corlett. 18. Treatment of Chronic Ringworm in an Institution for boys—Dr. L. A. Duhring. 19. Notes of a case of acute Dermatitis Exfoliativa—Dr. J. E. Graham. 20. Note relative to Pemphigus Vegetans—Dr. J. N. Hyde. 21. A study of Mycosis Fungoides with report of a case—Drs. H. W. Stelwagon and H. Leffingwell Hatch. 22. Lymphangioma Circumscriptum with report of a case—Dr. M. B. Hartzell. 23. Remarks on Carbuncle with report of a peculiar case—Dr. H. G. Klotz. 24. Note on Erythema et Nævus Nuchæ—Dr. C. W. Allen. 25. A case of Lichen Ruber—Dr. J. Grindon. 26. The personal equation in Dermatology—Dr. L. D. Bulkley. 27. The hypodermic use of Hydrargyrum Formamidatum in syphilis—Dr. R. B. Morrison. 28. Retarded hereditary syphilis—Dr. R. B. Morrison. 29. Epilation, its range of usefulness as a dermato-therapeutic measure—Dr. J. Zeisler.

## Book Reviews.

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A PRACTICAL TREATISE ON DISEASES OF THE SKIN. By Henry G. Piffard, A. M., M. D., Clinical Professor of Dermatology, University of the City of New York. Assisted by Robert M. Fuller, M. D. New York. D. Appleton & Co.

An eminent dermatologist said of the numerous pictures of skin diseases, that you might place one of them before a number of dermatologists, and each one, not seeing the name beneath, would call the representation a different disease. The plates and cuts in the work of Dr. Piffard are better than some which have been presented, yet we find the same objection as above mentioned.

One notable departure in the work is the failure to attempt a set classification of the various skin eruptions. This, alone, is an advantage in favor of the work, for nothing is more difficult and confusing than the effort to keep up with the classifications given by the various authors.

As we would expect from one of Dr. Piffard's ability, the text is well written, practical and will prove a useful guide to physicians who consult its contents.

He closes the work with an exposition of his own views regarding psorosperms, to which various diseases of the skin have, within the past few years, been attributed. M. B. H.

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DR. JOHN B. HAMILTON has resigned the position of Surgeon General U. S. Marine Hospital Service, to accept the Professorship of Surgery in the Rush Medical College, Chicago. Dr. Walter Wayman, for many years Dr. Hamilton's chief assistant in the Marine Hospital Service, succeeds him as Surgeon General.

ARTICLES OF AGREEMENT BETWEEN THE  
MEDICAL COLLEGES OF THE STATE  
OF GEORGIA, 1891.

For the purpose of securing uniformity of action, and maintaining the rates of tuition, the Medical Schools of the State of Georgia, by their official representatives, hereby agree to the following rules for the government of the several institutions, to remain in force until formally annulled.

*First*—**FEES**—The regular fees for each course of lectures shall be as follows: First term—Matriculation Fee, \$5.00; Lecture Fees, \$100.00; Dissecting Fees, \$10.00; total, \$115.00. Second term—Lecture Fees, \$100.00; Diploma Fee, \$30.00; no Matriculation Fee, and no Dissecting Fee, unless the student dissects. Third term, when taken, will be given without any charge to such students as have paid for two full courses of lectures. This rate of tuition, which is a return to the fees of former times, will take effect with the beginning of the session of 1891-92.

*Second*—**PAYMENTS**—All fees, as far as possible, are payable at the opening of the term, though, it is left discretionary with executive officer of each institution, to make any business arrangements he may see fit for the payment of the balances during the term, provided always, that all indebtedness, including the diploma fee, shall be cancelled before the first of February.

*Third*—**PAYMENTS BY NOTE**—When circumstances shall arise that render the cancelling of the entire indebtedness of the student in cash impracticable, and when the faculty deem it expedient to accept the note of the party, the note taken must bear an endorsement that not only renders the same safe, but negotiable and collectible without trouble.

*Fourth*—**BENEFICIARIES**—There shall be no departure from the published rates of tuition except as follows: The Medical College of Georgia and the Atlanta Medical College, having at a former day received money from the State, are required by law to furnish free tuition to thirty students, the former twenty and the latter ten. These being governed by

law and not subject to the control of the schools, it is agreed that the Southern Medical College be permitted to receive as many as ten students on similar terms, or at such reduction as they may see fit. Beyond the above number allotted to each school there shall be no reduction of any character whatever from the published rates of tuition, and it is further agreed that each college shall keep a record of the names of the students for whom such reductions are made, with the amount of the reduction and the reason therefor.

*Fifth*—LIMIT OF ADMISSION—The time of entrance of students must be so regulated that no one shall lose more than one-fourth of the regular session for any cause. This time of attendance is prescribed by statute in the State, and a penalty attached to its violation. It is further agreed that each school shall at intervals of one week call the roll of the class by its executive officer, and note absentees, and the amount of time lost by them ; and such roll call shall not be made upon stated days, but at the discretion of the Dean of the school.

*Sixth*—It is agreed that, for the mutual protection of the colleges against the charge of bad faith, and for the better understanding of business, the books of each shall be open to the inspection of the others as may be deemed advisable, and at the end of each term there shall be exchanged reports, showing the number of students in attendance, the amount of money received in cash, and the amount and kind of obligations taken in lieu of cash, such reports being made, if required, under the oath of the Dean of the school.

*Seventh*—Any school found guilty of a violation of this agreement shall be publicly noted as having failed in its obligation.

EDW. GEDDINGS, M. D.,  
Dean Med. Dept. Univ. of Georgia.

WM. PERRIN NICOLSON, M. D.,  
Dean Southern Medical College.

W. S. KENDRICK, M. D.,  
Proctor Atlanta Medical College.

# THE ATLANTA AND MEDICAL SURGICAL JOURNAL.

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## Original Communications.

### LACERATION OF THE ANTERIOR VAGINAL WALL AND ITS REPAIR.\*

BY T. J. WATKINS, M. D., CHICAGO.

Laceration of the anterior vaginal wall has hitherto received little attention. Emmet \*\* and Schatz † have considered this subject only in its relation to rupture of the levator ani muscle, and state that its repair is impracticable. Mundé ‡ reports a case of median separation accompanied by hernia of the bladder.

Byford § is, so far as I have been able to ascertain from a somewhat extensive study of the literature, the only author who

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\*Read before the Gynecological Society of Chicago, April 17th, 1891.

\*\*"Principles and Practice of Gynecology," page 264.

†Centralblatt für Gynäkologie, No. 40, 1883.

‡American Journal of Obstetrics, June, 1890, page 614.

§"The Practice of Medicine and Surgery applied to the Diseases and Accidents Incident to Women," fourth edition, pages 173, 479, and 501.



has appreciated in any degree the true nature of the lesion, and the only operator who has suggested a rational method for its repair.

In the consideration of lacerations of the pelvic floor, all the authorities, so far as I have been able to determine, have considered only the rupture of its muscles. It is unphysiological to attribute continuous support to muscles, therefore the connective tissue alone remains to be considered. The connective tissue of the anterior vaginal wall forms a tense, firm band across the vagina opposite the neck of the bladder, which becomes gradually thinner as it approaches the uterus and as it extends along the urethra. It is attached to the bony pelvis on either side, and its reticular arrangement is such that it permits much more longitudinal than transverse freedom of motion—that is, it is so arranged as to give elastic support to the uterus, and to prevent prolapse of the urethra and bladder. The tension which this band gives to the vagina is apparent to the touch; and on introducing a Sims speculum, with the patient in the left lateral position, the effect upon the anterior vaginal wall can be easily seen, that is, from the introitus vaginae to the uterus the anterior vaginal wall presents:

1. A convexity corresponding to the urethral curve.
2. A marked concavity opposite the trigone of the bladder.
3. A straight line or a slight convexity from this point to the uterus.

When this fascia is intact and involuted, urethrocele and cystocele cannot occur. The prevailing theory that urethrocele and cystocele are dependent upon and cannot occur without laceration of the posterior vaginal wall is erroneous, because—

1. Extensive laceration of the posterior vaginal wall even through the sphincter ani, frequently occurs without urethrocele or cystocele.
2. Urethrocele and cystocele occur without laceration of the posterior vaginal wall.
3. Incision of the posterior vaginal wall—that is, artificial laceration—never produces urethrocele or cystocele.

This time-honored fallacy may be explained by the fact that

both walls of the vagina are often simultaneously ruptured, and that the posterior rupture is much more apparent than the anterior.

Laceration of the anterior vaginal wall may be either unilateral or bilateral. I have never met with a case of median laceration, and have been able to find only one case on record.\* The lesion is usually submucous, and occurs at or near the insertion of the fascia into the bony pelvis. It often deprives the horizontal rami of the pubes of their fascial covering for a variable distance from the urethra, and may involve the levator ani muscle, as mentioned by Emmet and Schatz.† The location and extent of the laceration are easily detected by touch, and verified by inspection of the abnormal curvature of the anterior vaginal wall. The amount of the urethrocele and cystocele which result is entirely dependent upon the extent and location of the laceration, and upon the amount of involution which has taken place.

*Etiology.*—The child's head, in its passage through the parturient canal, may produce laceration of the anterior vaginal wall—

1. By the tension and pressure incident to the engagement of the vesico-vaginal septum between it and the pubes.
2. By tearing and grinding of the connective tissue from its attachment.

Schatz† mentions anterior laceration of the levator ani muscle by instruments, and advises against oblique application of forceps.

*Symptomatology.*—The objective symptoms have already been considered. The subjective symptoms, which are dependent upon the amount of urethrocele and cystocele, are—

1. Partial incontinence of urine. The urine escapes upon exertion, such as coughing, sneezing, laughing, walking, lifting, or as soon as the desire to urinate is experienced.
2. Total incontinence of urine.

The other subjective symptoms are those which are described

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\*Munde, *Op.* cit.

†*Op.* cit.

in the text-books in the consideration of cystocele and prolapse of the uterus.

*Diagnosis.*—The diagnosis depends upon the recognition of the local lesion and of the resultant symptoms.

*Treatment.*—I. Prophylaxis. The prophylactic treatment consists—

1. In the support of the vesico-vaginal septum while the foetal head is entering the true pelvis—that is, the prevention of the engagement of the vesico-vaginal septum between the head and the pubes.

2. In the prevention of excessive pressure of the head upon the pubic arch (Schatz).

3. In the employment of the usual measures for hastening involution.

II. Operation. The rational operative treatment is to restore, as far as possible, the lacerated fascia to its normal condition. The usual operations on the anterior vaginal wall have failed to accomplish this result, because—

1. They roll together tissues not involved in the laceration.
2. They include so little connective tissue that, as a rule, no permanent support is obtained.
3. Retroposition of the uterus frequently follows.
4. They produce little or no effect upon the urethrocele.

The multiplicity of median operations on the anterior vaginal wall would seem to indicate that the results of these operations have been more or less unsatisfactory.

An operation to be rational—

1. Must be upon the portion of the anterior vaginal wall which has been torn—that is, it must bring together, as far as possible, the lacerated tissues.
2. Must include much of the pelvic fascia of the anterior vaginal wall.
3. Must neither shorten the anterior vaginal wall nor bring the lateral walls of the vagina together in front of the uterus.

The unsatisfactory result of the median operation induced me to attempt a lateral operation which I have performed twenty

times, and which has in every case practically fulfilled the indications.\* The technique is as follows :

The patient being placed in the left lateral position, the anterior vaginal wall is exposed by Sims' speculum, and a point to the side of the urethra, near its meatus, caught by a tenaculum. The denudation is commenced at this point, and extends along the antero-lateral walls of the vagina to a point beyond the prolapse. This point may be opposite the neck of the bladder, or the denudation may extend even as far as the lateral aspect of the cervix uteri. The breadth of the denuded surface is dependent upon the extent of the urethrocele and cystocele ; that is, it should be sufficiently wide to take in all the redundant tissues of the urethrocele and cystocele. The denudation may be upon one or both sides, according as the laceration is unilateral or bilateral. Should the denuded surface extend beyond the neck of the bladder, the cervix uteri should be drawn firmly upward and backward while the sutures are being inserted and tied. For this purpose I have adopted the method recommended by Dr. E. C. Dudley, in the technique of Emmet's anterior colporrhaphy†, of fastening the cervix uteri to the end of the speculum by means of a suture.

Beginning at the uterine end of the denudation, buried silk-worm-gut sutures are now passed from side to side in a curved line which has its convexity directed outward and forward. Each suture as inserted is tied, and traction is exerted toward the cervix while the next suture is being introduced and tied. The sutures should include as much connective tissue as possible, care being taken not to injure the bladder, ureters, or urethra. After passing the base of the trigone of the bladder, the sutures should be passed deeply into the lateral wall so as to include the fascia of the posterior vaginal wall near its insertion into the pubes, and as deeply into the anterior vaginal wall as the increased thickness of the vesico-vaginal septum from this point outward will permit. The fixation suture should now be re-

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\* Dr. John A. Lyons, of this city, has performed this operation three times with results practically identical with my own.

† Pepper's "System of Medicine," page 162.

moved without making traction on the cervix. The ends of the sutures should be left long and should be turned into the vagina.

The after-treatment consists in the measures usually employed in plastic operations upon the vagina. The use of the catheter should, if possible, be avoided. The stitches may be removed after a week, or may be allowed to remain for two or three weeks, according to the requirements of the individual case.

The operation has entirely fulfilled both the mechanical and symptomatic indications, except in one case, in which, on account of suppuration around some of the sutures, only partial relief was obtained. Up to this time, so far as I have been able to ascertain, the results of the operation have been permanent.

I append a tabular statement of the twenty cases in which I have performed this operation, and of the three cases operated upon by Dr. Lyons.

See table on following page.

TABULAR STATEMENT.

No.	Name.	Date of Injury.	Lesion.	Indications.	Date of Operation.	Result.
1	Mrs. H.....	1885	Bilateral laceration...	Urethrocele. Total incontinence of urine.....	February, 1890....	Cure.
2	Mrs. C.....	1890	Unilateral laceration	Urethrocele. Total incontinence of urine.....	February, 1890....	"
3	Mrs. C.....	1887	Bilateral laceration...	Urethrocele. Cystocele. Prolapse of uterus. Partial incontinence of urine.....	March, 1890.....	"
4	Mrs. T.....	1888	"	Urethrocele. Partial incontinence of urine.....	March, 1890.....	"
5	Mrs. F. <sup>s</sup> .....	1882	"	Urethrocele. Cystocele. Total incontinence of urine.....	April 3d, 1890....	"
6	Mrs. K.....	1887	"	Urethrocele. Cystocele. Partial incontinence of urine.....	June 6th, 1890....	"
7	Mrs. T.....	1888	"	Urethrocele. Cystocele. Partial incontinence of urine.....	June 9th, 1890....	"
8	Mrs. N.....	1885	"	Cystocele. Prolapse of uterus.....	June 15th, 1890....	"
9	Mrs. W.....	1886	"	Urethrocele. Cystocele. Partial incontinence of urine.....	July, 1890.....	"
10	Mrs. D.....	1886	"	Urethrocele. Partial incontinence of urine.....	July, 1890.....	"
11	Mrs. Y.....	1889	"	Cystocele. Prolapse of uterus.....	August, 1890.....	Part'l relief.
12	Mrs. C.....	1882	"	Urethrocele. Cystocele. Prolapse of uterus. Partial incontinence of urine.....	Sept. 22d, 1890....	Cure.
13	Mrs. H.....	1884	"	Urethrocele. Partial incontinence of urine.....	Sept. 27th, 1890....	"
14	Mrs. E.....	1888	"	Urethrocele. Cystocele. Prolapse of uterus. Almost total incontinence of urine.....	Oct. 6th, 1890.....	"
15	Mrs. S.....	1887	Unilateral laceration	Slight urethrocele. Partial incontinence of urine.....	November, 1890....	"
16	Mrs. H.....	1887	Bilateral laceration...	Urethrocele. Slight cystocele. Partial incontinence of urine.....	December, 1890....	"
17	Mrs. McG.....	1885	"	Urethrocele. Cystocele. Partial incontinence of urine.....	Dec. 10th, 1890....	"
18	Mrs. M.....	1884	"	Urethrocele. Cystocele. Prolapse of uterus. Partial incontinence of urine.....	March 4th, 1891....	"
19	Mrs. C.....	1886	"	Slight urethrocele. Partial incontinence of urine.....	March, 1891.....	"
20	Mrs. A. B.....	1888	Unilateral laceration	Slight urethrocele. Partial incontinence of urine.....	March, 1891.....	"
21	Mrs. F. <sup>s</sup> .....	1888	Bilateral laceration...	Urethrocele. Cystocele. Partial incontinence of urine.....	Sept. 3d, 1890....	"
22	Mrs. H. <sup>s</sup> .....	.....	"	Urethrocele. Cystocele. Partial incontinence of urine.....	Sept. 25th, 1890....	"
23	Mrs. G. <sup>s</sup> .....	1890	"	Urethrocele. Cystocele. Partial incontinence of urine.....	March 15th, 1891....	"

<sup>1</sup> In the six cases in which prolapse of the uterus was one of the indications for the operation, the result, as far as this condition is concerned, must be understood to refer only to the effect produced upon the uterus by the restoration of that portion of its elastic support furnished by the anterior vaginal wall.

<sup>2</sup> This patient had already undergone two median operations without any relief.      \* Cases operated upon by Dr. Lyons.

## HYSTERIA : REPORT OF A STRANGE CASE.\*

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By JOHN POPE STEWART, M. D., ATTALLA, ALA.

Counsellor Elect of the Medical Association, State of Alabama.

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I have selected for your entertainment a disease called hysteria. I do not mean as it is understood by the laity, or even as it is understood among some of the profession; neither do I mean hypochondriasis, or any trouble speculative, imaginary or conjured.

But I propose to entertain you with the description of a disease most wonderful in its nature, most obscure in its etiology, most marked in its symptoms and one that has as yet remained a mystery to the etiologist, the microscopist and the pathologist. And while calling your attention to this, I shall describe one of the strangest cases I ever saw or ever read of.

The bacillus of hysteria is an undiscovered proto-germ, the pathology an unobserved abnormality; *post mortem* investigation has given no clew to the morbid process. And yet, hysteria is a true and legitimate disease, most difficult to manage and most unsatisfactory to treat.

Hysteria is a disease of the nervous system; that every one will admit, but what part of the nervous system? The brain, the spine, the sympathetic? All, or a few, one or more? If it affects the brain, in what way does it affect the brain? Like cold, like heat, like compression, like concussions, like inflammation, like congestion, like depletion, like paralysis, like anæsthesia? Wholly or in part, or what? Echo answers, "What?"

The fool has hysteria, the most intelligent, the most illiterate or the best informed. A functional nervous disease without organic lesion, without a pathology, without morbidity, without a microcity; and yet, gentlemen, a disease, and should be called by its name, and those who are suffering from it should be informed of their trouble intelligently, instructively and minutely;

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\*Read before Alabama State Medical Association.

so that they will understand that on their part it is an uncontrollable trouble, and that they are not suspected of sham.

Hysteria, as I said before, gives nothing to morbid anatomy, the brain, the spinal cord, the sympathetic nerve gives no evidence as to its having been present. Hysteria rarely causes death, but hysterical patients dying of intercurrent affections have been examined after death most searchingly for some evidence of this disease, yet nothing has been found. Looking at the brain as a complex organ from which is evolved a conglomerate force called the mind, we can easily appreciate disorders of its functions that are not absolute lesions, the effect of which might be excess or diminution in quality, tone or action. The mind, as we know, is made up of several sub-forces, such as the perception, the intellect, the emotions, the will, etc., and when any one of these become disordered, we have those degrees of insanity which follow each several sub-force diseased. Well, hysteria, we are compelled to admit is purely a physical trouble, and essentially consists in the predominance of the emotions over the will, and to a certain degree the intellect. An example familiar to you all, of the influence of emotion over the will, is demonstrated in the emotion of fear; it renders the sensibility more acute and produces trembling or clonic spasm; again, in brief we have tonic contractions. In surprise or horror we get paralysis of muscular action, joy or anger destroys sensibility to pain, etc. These examples show how the emotions can predominate over every other sub-force of the strongest mind for a short duration of time. So in hysteria, during the exaltation of the emotional power, the power of the will is not only relatively (like in fear, joy, etc.) but absolutely diminished, and these two factors, acting together, the one exalted, the other diminished, continuously, persistently and steadily, produce many of the manifestations of this disease.

The spinal cord, no doubt, and its accessories is secondarily affected, for through the spinal nerves, you know, we have the variety of convulsions, spasms, contractions and the paraplegic and hemiplegic phenomena found in this as well as other diseases.



To detail a differential diagnosis of hysteria with other diseases would take volumes. The physician must be his own judge, for almost every known disease is simulated, and it takes no end of trouble sometimes to tell the true from the false. The hysterical patient tries with utmost and consummate skill to impress others with the belief that they are very, very sick, even unto death. They will try to arouse your sympathy, and failing in that, your fears, and leave nothing undone that will lead you to a belief in their dangerous condition. But careful watching and thorough skepticism on the physician's part, and his diagnosis will be easy. But after you have determined that the trouble is hysteria, you have at last a disease and one that is extremely difficult to manage, so you have, in jumping out of the frying-pan, got into the fire.

Hysteria appears commonly among females. I say commonly, for I have observed many instances where the opposite sex has suffered with this trouble. It attacks the old and young alike, and even has been noticed in infancy. However, it most frequently appears between the ages of ten to thirty years. The most constant and important, and, I may say, consistent factor in the etiology is heredity. This has been observed more than any other point in its history, yet this fails in as many cases as it proves true, and unless every little nervous foible or mental peculiarity can come under the head of hysteria, this supposed heredity is a fallacy.

Other supposed causes for hysteria are almost as groundless. I had some of the worst of cases to which I could attribute no cause whatever, yet it would be well to append just here a list of some of the causes predisposing hysteria, viz. : Ill-directed training of the mind, depressing influences, unhappy surroundings, desires ungratified, continued anxiety, the advent of other diseases, especially diseases of the reproductive organs, menstruation, pregnancy, severe trauma, shocks, physical or mental.

One of the most remarkable cases, however, I ever had, came upon a young lady at the supper table. She, with the family, was partaking of the evening meal, and without any warning or any shock of any description, without any trouble of any nature

to which I could attribute a cause, she was seized with a hysterical fit; screamed and laughed and cried alternately; shivered with cold one minute and burned with fever another; was dying this minute, and again felt well and perfectly happy the next; hated everybody this instant, the next loved the whole world; and, in fact, a psychical phenomenon and a symptomatic puzzle. This patient, after six or eight of these attacks, has, under treatment, recovered, and bids fair never to have any more.

The prognosis of hysteria from a single paroxysm of any kind is of course favorable, provided proper treatment is employed, but as to liability to a return of further attacks, much depends on circumstances, the surroundings of the patient, and the time that they have been subject to the trouble. All these have to be taken into consideration.

Under unfavorable circumstances, I wouldn't advise any physician to take charge of a case of this nature, unless there was plenty of money in it, for that would be the only satisfaction he would ever get out of it. For hysteria is purely an emotional disease, and any unfavorable or disagreeable surroundings will set this sub-force into wonderful activity, and your patient is like a roaring maniac, or has gone off into a trance, or has taken on violent convulsions. In fact, a storm has suddenly come up when you thought all was fair weather.

The most remarkable manifestation of hysteria is the epileptiform. This is, I presume, a rare trouble, and is called hysterio-epilepsy. I only had one case, and I think it a most extraordinary one, equaling fully the cases related by Charcot and M. Bournville of Madame Leo and Mademoiselle Louise Lateau.

On the morning of January 5th last I was called to see a lady whom I will call Miss M. I walked into the room and found her sitting up in the bed, her forehead pressed forward against her knees, her arms drawn round till the backs of her hands rested against her sides. Her feet were curved over and under. Her face was contorted all out of shape. Thus she was, moaning distressingly, her friends standing around her crying and taking on like they thought she was going to die every minute. I had never seen her before, therefore couldn't tell what

the trouble was. I gave her a large dose of morphine hypodermically and chloroformed her, and while she was relaxed and resting under this treatment I took my bearings, conferred with the family, and this is the result :

Miss M. is a maid, 24 years old, black curly hair, large brown eyes, arching black brows, beautiful even, white teeth, large mouth, red lips, form spare made yet symmetrical, skin dark, muddy, goosefleshed and scaly. Her history, as I have gathered from time to time, is that she has been subject to these attacks for four years. She has been treated by five or six doctors, and has gone through the whole *materia medica* in the way of physic, and has had uterine treatment of various kinds. She was wearing a stem pessary for prolapsus at this time.

Her mother is hysterical, of the pretending kind, a virago and a shrew. Her father is a simple-minded rustic. She has a brother in the Alabama Insane Hospital, and another that ought to be in the coal mines. Miss M. herself is fairly intelligent, quick to understand and a bright talker.

The next day the attack returned and I had a good opportunity to see her through it from beginning to end. She began with a slight trembling in her hands, then her arms, then her shoulders, head, neck, legs, until at last the whole body was shaking as with an ague. This grew more and more distinct until it resembled clonic spasms as in epilepsy. This lasted about an hour, then suddenly the spasms became tonic and the body would be drawn up in the tetanus form until only the back of the head and heels would touch the bed. This lasted two or three minutes, and then she dropped back to again slowly rise in the same position. Repeating this some five or six times, she suddenly changed into clonic spasms again, mostly with the head shoulders and arms, which began *poco* at first, rapidly getting *allegro* and finally quite *fortissimo*, her teeth chattering together and her eye snapping rapidly. This lasted about twenty minutes, then a tonic spasm of the muscles of the neck followed, drawing her head back until it seemed to lie between the shoulder blades. Her hands and arms were drawn over and under, the pectoral muscles seemed affected and breathing became quite difficult.

She moaned and gasped for breath. This lasted ten minutes, then again rapid clonic spasms took place, jerking her head about like a bell clapper. This anon ceased, and she shut up like a knife, her head being drawn down to her knees, and if we tried to lay her down her legs would follow. Again the tonic gave way to clonic spasms, and clonic to tonic. Sometimes she would be drawn laterally, sometimes forward, sometimes backward. A hand alone would be affected, again a foot, a leg, an arm, the neck, the back, the abdominal muscles, and again the whole body. She would assume various positions. I have placed her feet in a chair and head on the bed when she would be in the tetani-form condition, and she would hold up from two to five minutes. Another peculiar motion she had was a spasmodic beating of her buttocks rapidly against the bed while on her back, such as Hammond calls *hysteria libidinosa*. Sometimes she would get perfectly still, nothing moving except her eyes, her head thrown far back, and seemingly hunt for something with her glance over the headboard, giving a grunting moan the while, and now and then jump as if she had discovered what she sought and that it frightened her. She is conscious most of the time during an attack, and will constantly call your attention to the manner in which her trouble is affecting her. There are moments, however, that she seems to know nothing. She has great difficulty in swallowing and is often strangled with a little water. Her mouth gets as dry as a bone. Her breath is dry, hot and offensive. She sweats like a horse when she is working through one of these spells. She often chews "at" her tongue, but never wounds it. She grinds her teeth so hard and loud that it makes one's flesh creep to hear her.

She twice has assumed the cruciform position and became cataleptic. In her most rigid state she is perfectly conscious and makes plaint of the pain that accompanies each spasm and calls them cramps.

She has great difficulty in making water, which is scanty and high colored. Her bowels are usually costive. Her menses are irregular and lacking in quantity and quality.

Her appetite is usually good, even just after an attack. She is very sore a day or two following a spell, and is unable to walk on that account and weakness together. She has a kind of rheumatism in her left side, hip and legs. There is no swelling or other symptom to locate it. She feels it, nevertheless, she says.

There is no perceptible change in the heart's action. Throughout one of the attacks it remains strong and steady and beats away with normal regularity.

There is no change in the pupil of the eye; neither contraction nor dilatation of the slightest degree can be detected at any period of the attack.

She has an attack about once a week. Sometimes, however, she may have four or five during a week. She is not particular as to date or time of day or night, however. She has not gone longer than a week for the last eight or ten months. Their duration is never the same. They may begin in the afternoon and run on all through the night, to rest a few hours, to start up again and last another ten to sixteen hours; or, again, they may not last over an hour or so; and, of course, they do not run through her whole programme at each engagement.

One peculiarity I have noticed, and by it have been led to believe that there was some method in her madness. If there is a large crowd of friends or acquaintances around her bedside, to sympathize with her and to make exclamations of wonder and astonishment, and especially if there happens to be a new face present, she, it seems, goes through her whole performance for their benefit.

She suffers greatly with headaches all the time during the intervals as well as the attacks. She has a continual pain in the left ovarian region, of a dull nature, during the intervals, that grows very acute during an attack. Her stomach is a great source of trouble, and seems always deranged. She vomits often during the paroxysm and especially immediately afterwards.

During the intermissions of these phenomenal periods her whole talk and conversation is concerning her condition. Her whole time is taken up by relating to new acquaintances the history of her trouble and its many peculiar manifestations. She

has no aim or object in life. She doesn't try to do anything, only surprise her family and physician by developing some new feature into her seance.

My treatment has been along the usual line of remedies for hysteria, such as moral suasion, reasoning, kindness, sympathy, sarcasm, acerbity, anger, terror. Everything in that line failed. I gave her the bromides of potassium, calcium, sodium and zinc, and then mono-bromate of camphor, also electricity, strychnia, phosphorus and iron. All failed. The paroxysms would return with just as much force and last just as long. It looked like pouring water into a sinkhole for all the good that my treatment had done. I also employed other remedies for her uterine troubles and for the irregularity of the catamenia. I believe that I have omitted to mention that she was troubled with an irregularity of this nature and that she would go from five to six weeks sometimes, and during the menstrual period her hysteropileptic paroxysm would be the most violent.

And now for the sequel, three weeks ago I ordered from Birmingham 15 grains of the chloride of gold and sodium. I gave her the first dose the 1st day of April. Since then she hasn't had a single symptom of her trouble. I'm giving her the 20th of a grain of the double chloride three times a day in an aqueous solution. Last Thursday, the 9th, her menses appeared after six weeks' delay, and was on her last Monday night, when I saw her last. Yet she has had no further symptom of hysteropilepsy, and this has been my sole treatment for two weeks, except I am using suppositories of iodoform in the vagina and holding or supporting the prolapsed uterus with cotton tampons.

I know very little about this chloride of gold, this being my first use of it, and I can't say that the benefit I have derived from its use is going to be permanent, as I have employed it only a fortnight. Yet, in that short time, it has accomplished wonders in my case of hysteropilepsy.

VOMITING OF PREGNANCY—ITS ETIOLOGY  
AND TREATMENT.\*

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BY F. BLUME, M. D., ALLEGHENY, PA.

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Pregnancy, as a rule, is complicated with a variety of disorders, which, though in many instances causing much discomfort, are termed physiological as long as they are not associated with serious disturbances of the organism. Derangements of the gastro-intestinal canal, nausea and vomiting, to the consideration of which I invite your attention to-night, are such a regular occurrence during the early period of pregnancy that experienced women consider them as positive signs of conception.

The so-called morning sickness—nausea and vomiting early in the morning, or even after meals during the first few months of gestation—have, in the large majority of cases, no effect either upon the course of pregnancy or upon the health of women. Although the ordinary morning sickness sometimes persists during the whole period of pregnancy, it remains endurable, causing the patient rather annoyance than injury. There are intermissions, either spontaneously or the consequence of some treatment, the digestive functions remain more or less normal, and the vitality of the patient is not essentially impaired. In some, fortunately very rare instances, however, nausea and vomiting become incessant and uncontrollable, the stomach rejects everything, the patient grows weaker until the most extreme degree of exhaustion is reached, and death from starvation threatens.

The onset of this grave form of the affection is gradual, and does not differ in character from the usual morning-sickness. But soon the nausea becomes more intense, the vomiting more frequent. The ejected matter consists of food, mucus and bile. The appetite is more or less impaired or perverted; the thirst is excessive; constipation is more frequent than diarrhœa; the urine is scanty, concentrated and contains albumen and casts. The

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\* Read before the Allegheny County Medical Society, June 16, 1891.

pulse grows small and rapid, the temperature rises and continued fever develops.

With the progress of the disease the condition of the patient becomes more and more alarming. The nausea is almost constant, adding greatly to the discomfort of the woman. The efforts at vomiting are accompanied by violent retching and pain, not the smallest amount of food or drink is retained by the rebellious stomach, the smell, even the thought of nourishment, or the slightest movement of the patient, induces an attack. The vomited matter is finally mixed with blood. The thirst is tormenting, the throat and mouth are dry, the tongue brownish, the breath fetid, the abdomen tympanitic. The consequences of this continued suffering soon become very pronounced by the marked alteration of the features, the extreme emaciation, and the profound depression of the patient. Shortly before life ends vomiting ceases and coma supervenes.

Cases of persistent vomiting, which terminate fatally, are certainly very rare. Even after the application of various methods of treatment has failed to influence the course of the disease, and while the induction of abortion was earnestly considered, the patients have recovered spontaneously, and have gone to full term, as I have seen in the only instance of this grave disorder which has come under my observation.

There is considerable diversity of opinion as to the causes which may incite hyperemesis, and, in spite of numerous theories and hypotheses, the etiology is by no means clear. It is almost universally accepted to be a reflex neurosis originating in the uterus, and dependent either upon pregnancy alone or upon co-existent pathological conditions.

Pregnancy itself, the growing ovum, which acts as an irritant by the simple mechanical distention of the uterine cavity and its peritoneal covering, is in the first place to be mentioned as the most potent etiological factor.

Cases of multiple pregnancy and hydramnion, which present a disproportion between the passive distention and the active growth of the uterus, and which frequently are complicated with hyperemesis, confirm this view. Moreover, the induction of arti-



ficial abortion, our last resource in desperate cases, which almost immediately relieves the patient when done in time, is founded upon this theory of passive uterine distention, and strongly supports it.

Spontaneous death of the foetus, followed by immediate or remote abortion, is another remarkable fact in favor of this view.

A patient of mine, the mother of two children, was suffering from double laceration of the cervix, erosion and endometritis.

She refused surgical treatment, and was relieved by repeated irrigations of the uterus with carbolized water, and by the application of tincture of iodine. She soon afterward conceived, and her pregnancy was complicated with the ordinary morning-sickness from the second month to the beginning of the sixth, when the vomiting suddenly ceased. Two weeks thereafter she told me that she did no longer feel the movements of the foetus, that vomiting had ceased, and that she therefore believed the child was dead. Though I could not detect the foetal heart-sounds, I gave my opinion with reserve. Three and a half months later I delivered her of a dead foetus about five months old.

This case affords the most striking evidence of the discontinuance of reflex symptoms after the removal of the inciting cause. We have here pregnancy complicated with pathological conditions of the uterus, as double laceration of the cervix, ectropium and probably a but partially cured endometritis, conditions which existed prior to conception and continued after the death of the foetus. But in spite of the persistence of these pathological conditions of the uterus, and of the retention of the dead foetus for almost four months, the vomiting disappeared with the death of the foetus, that is, with the cessation of the mechanical distention of the uterine cavity.

The influence of primary gravidity is demonstrated by the fact that hyperemesis in its grave forms is essentially an affection of primiparous women, and it is to be referred to the greater resistance of the virginal uterus.

Numerous other causes are given as etiological factors by different observers, among them: pathological conditions of the cervix, chronic metritis and endometritis, displacements of the

uterus, inflammations of the pelvic peritoneum and connective tissue, ovarian neurosis, neurotic predisposition, hysteria, and lastly, diseases of the gastro-intestinal canal, especially gastric ulcer, chronic gastritis and constipation.

Morbid changes of the uterus are frequently the cause of reflex neuroses in non-pregnant women. The dependence of gastric disturbances upon the irritability of the uterine nerve-fibers, due to flexion and version of the uterus, to an eroded and congested cervix, to metritis and endometritis, has, in many instances, evidently been proven. Relief has been obtained by the removal of the exciting cause, by the treatment of the uterine diseases after gastric medication had been tried again and again and had failed entirely.

Bearing in mind the physiological changes of the uterus during the pregnant state, its increased functional activity, the influence exerted by the gestation upon the nervous system, and the relation between the neuroses and the disorders of the reproductive organs, so often conclusively proven in non-gravid women, we are compelled to acknowledge the various pathological conditions of the uterus as prominent etiological factors deserving our earnest attention. Cases are on record where the application of caustics to the eroded cervix, scarification of the congested vaginal portion, dilatation of the cervical canal, correction of a flexion, have proven successful in stopping the vomiting, and thus demonstrated the connection between the uterine lesion and the reflex nerve action. In other instances, however, the result of the gynecological treatment has not been so satisfactory, either transitory or no relief has been obtained, and, as a consequence, the influence of the uterine disorders upon the gastric phenomena, their importance as the causative diseases has been questioned.

Undoubtedly it will be often found difficult to decide whether the symptoms result from physiological or pathological causes; whether they are due to distention of the uterus or to morbid changes in the sexual organs. All methods of treatment, artificial abortion excepted, may fail to relieve the patient, and she

finally may get well by absolute rest and complete abstinence to the surprise of her medical attendant.

Such cases are certainly rare, while, on the other hand, there is abundant clinical evidence of the effect of local treatment. Numerous women have been benefited by the treatment of the uterine lesion; the reflex symptoms have been mitigated or cured by the improvement of the causative disease, and the connection between both has thereby been confirmed.

Attention has been drawn to the importance of endometritis as an etiological factor by F. Veit,\* who reported three cases of uncontrollable vomiting, where he was compelled to interrupt pregnancy, and where he found inflammatory processes in the decidua, serotina and vera. Veit believes that by his researches the dependence of hyperemesis upon endometritis is positively proven. As a rule, the endometritis exists prior to gestation, the symptoms are but insignificant, become palpable, however, with the beginning of pregnancy, which frequently is interrupted by this complication. In many instances the endometritis decidua will be found to be the cause of the uncontrollable vomiting; the connection through sympathetic paths must be the same as between gastric disorders and endometritis in non-gravid women. The evidence of an anatomical base, he continues, renders a most careful examination of the uterus imperative, and, if the diagnosis of endometritis, which is very difficult before the removal of the ovum, can be made out, it may be of determining influence as regards the advisability of inducing abortion.

Quite recently E. H. Grandin,† discussing this subject in the New York Obstetrical Society, suggested ovarian neurosis, pressure on unusually hyperesthetic ovaries as a cause of hyperemesis. This view, he says, would be suggested by Dr. Coe's case, which showed that the physiological vomiting of pregnancy could be palliated by teaching the patient to assume the genu-pectoral position before rising, and as often during the day as necessary. He would explain the vomiting of pregnancy, then, by the fact that during the early months the uterus lay low in

\* *Berliner Clinische Wochenschrift*, 1887, p. 643.

† *American Journal of Obstetrics*, 1890, p. 1382.

the pelvis and pressed on the ovaries; at the third month, when the vomiting usually ceased, the uterus rose above the pelvic brim. In cases of pernicious vomiting it was possible the ovaries were either enlarged through disease or had become impacted between the pelvic brim and the lower uterine segment.

Grandin's theory, though it may be applicable to a given case, will probably not be favorably accepted. To-day the view is predominant that reflex-neuroses may originate in the uterus, and not in the ovary. The removal of normal ovaries for the relief of reflex symptoms is at present restricted to exceptional cases, and it is believed that if a satisfactory result is obtained by the operation, this is due to the changes in the condition of the uterus, to the artificial induction of the menopause, resulting from oöphorectomy. Clinical evidence supports this view.

Grandin's explanation, however, may prove valuable in so far as to induce us to carefully examine the ovaries in cases of hyperemesis. Prolapsed ovaries are by no means a rare affection, but it remains to be demonstrated whether pressure exerted upon them by the enlarged uterus stands in causal relation to gastric disturbance.

Nervous disposition and hysteria, so frequently met with among women of the better classes, add greatly to the discomfort of pregnancy, and, though there are certainly many exceptions, must be considered as prominent predisposing factors of the graver forms of vomiting.

The importance of diseases of the gastro-intestinal canal, especially of gastric ulcers, is emphasized by various authors. According to Horwitz,\* "hyperemesis develops in some cases complicated with more or less pathological changes of the stomach and of the intestines. The greater the disturbance in the alimentary canal the easier the ordinary vomiting takes on the character of the uncontrollable form."

The diagnosis of vomiting of pregnancy is by no means as easy as one might think at first sight. While the dependence of this disorder upon the pregnant state may often be determined

\* *Praktischer Arzt*, 1832, p. 261.

without much difficulty, cases—especially of the graver forms—may present themselves where this will be found impossible, and where the diagnosis, therefore, must remain doubtful. Faggard\* directs our attention to the fact “that so few cases of pernicious vomiting are recorded in German medical literature that the existence of this affection is even questioned.” Carl Braun, in a fabulous experience of over one hundred and fifty thousand obstetrical cases, has never observed a single fatal termination. On the other hand, Robert Barnes has himself seen 9 fatal cases. McClintock collected close on 50 cases, and O. W. Doe 48 cases, with 18 deaths, occurring within the last fifteen years, and registered in American and English journals. Gueniot records 118 cases with 46 deaths.

It is not at all improbable, Faggard continues, that the difference of opinion as to the frequency of this disorder between the Germans on the one hand, and the American, French and English observers on the other depends, in a large measure, upon the difference in diagnostic criteria insisted upon by the respective schools. In the majority of the fatal cases of alleged hyperemesis due to pregnancy reported by American, French and English observers, there is a notable absence of reliable records of *post mortem* examinations. In the few cases collected by the Germans, on the other hand, the diagnosis during life has almost invariably been confirmed or negatived by exact investigation of the dead body. Horocks pertinently remarks: “Where there has been no *post mortem* examination in a fatal case of vomiting, I do not think one is entitled to say that pregnancy caused the fatal vomiting. It may have been the cause, and the only cause, or it may have been an aggravation of some other cause, or it may have had nothing to do with it. Scepticism as to the alleged frequency of this disorder in the present state of our knowledge is accordingly eminently in order.”

According to Gueniot† three distinct factors are to be taken into consideration in making the diagnosis of vomiting of pregnancy: 1st. The diagnosis of pregnancy. 2d. The diagnosis

\* American System of Obstetrics, Vol. I., pp. 411, 415.

† Faggard, American System of Obstetrics, Vol. I., p. 416.

of the adjuvant or determining cause of the vomiting. 3d. The differential diagnosis between obstinate vomiting due to pregnancy and that due to other causes independent of gestation.

It is both interesting and instructive to learn that errors in diagnosis have been made even by eminent clinicians. Thus Faggard\* tells us that Trousseau once diagnosticated uncontrollable vomiting, and induced abortion in a case in which the autopsy revealed cancer of the stomach. Beau erred in diagnosis in a case to which the *post mortem* examination showed tubercular meningitis as the probable cause of the vomiting, and Cazeaux narrates the history of a fatal case of alleged hyperemesis of pregnancy where the autopsy disclosed tubercular peritonitis and the absence of pregnancy.

But a mistake in diagnosis is possible even in the other direction, that is, pregnancy may be denied by the patient or not be expected by the physician, and thus be overlooked, as shown in a case recently reported by A. H. Buckmaster.† The patient, a governess in a respectable family, was supposed to be suffering from vomiting due to ulcer of the stomach, and was under treatment two months when she died. In making the autopsy a five months' fœtus was found, but no ulcer whatever, nothing to account for death except the uncontrollable vomiting of pregnancy.

These cases need no comment. I have cited them to demonstrate both the difficulty and the importance of an accurate diagnosis.

It is generally stated that the prognosis of hyperemesis is bad, but this, apparently, is by no means correct. As Faggard justly remarks, "It is doubtful whether an authentic fatal case of this kind is recorded. Such cases have never been seen by observers of the largest experience."

Even the graver forms of this disease yield, as a rule, to rational treatment, unless they are complicated by serious pathological conditions which of themselves render recovery impossible. Pregnancy may aggravate such cases, and perhaps hasten death, but it must be admitted that there exists no causative relation between gestation and the lethal issue.

\*l. c.

† *American Journal of Obstetrics*, 1890, p. 1381.

A great variety of remedies—still increasing in number every year—have been recommended by different writers. These remedies have proven satisfactory in some cases, but failed entirely in others. This uncertainty of the various methods of treatment, the often but little annoyance caused by the milder forms of vomiting, and the experience that in many instances spontaneous cures occur, have led to the view that interference is not required unless the case presents a more serious aspect. Such advice given in text-books is, at first sight, surprising. Even in mild cases of gastric trouble a careful examination is indicated, and should be insisted upon by the medical attendant, to determine the cause of the disorder, its dependence upon physiological or pathological conditions. Are the generative organs found to be normal? Are there no indications of diseases of other vital organs, especially of the stomach? Is the effect of the vomiting upon the general health but insignificant? It may then be decided whether it be a wise plan to irritate the stomach by various drugs, which, as known from experience, are of so limited value in this reflex affection, or to desist from treatment. It is in this sense, I take it, that such advice has been given, and it is under these circumstances that it deserves recommendation. Nevertheless, such statements in text-books are misleading, fortunately, but to the superficial reader.

While cases of vomiting do well without treatment, diet and regulation of the bowels are usually sufficient to render the gastric disturbances tolerable but the persistent vomiting demands our earnest attention.

Hyperemesis, a reflex neurosis, is due either to physiological changes in the uterus, distention by the growing ovum, or to pathological conditions complicating pregnancy. If we exclude co-existent diseases of the stomach which will be considered later on, it must seem plausible that the treatment should be directed against the causes and not against the symptoms of the gastric disorder; that is, against the uterus, and not against the stomach. The stomach is not the diseased organ. Nausea and vomiting of pregnancy are only the symptoms of some functional disturbance of the nervous system, originating in the uterus, like the

nausea and vomiting of sea-sickness, an analogous disease, dependent upon the motion of the ship. For this reason gastric medications must fail to favorably influence hyperemesis; for this reason none of the innumerable remedies recommended are found to be reliable,—some of them are worse than useless.

There are three classes of cases, however, which sometimes may be relieved by the administration of drugs, viz.: 1st, Women, who prior to gestation, have been afflicted with diseases of the stomach, as chronic gastritis and gastric ulcer; 2d, women of an unusual nervous irritability; and 3d, hysterical women.

In cases of the first category sub-nitrate of bismuth, bicarbonate of sodium, Carlsbad water, oxalate of cerium, the tincture of nux vomica, etc., may be tried and may sometimes be found of decided value, while the nervines and sedatives may give relief to nervous and hysterical women. Opium and its preparations, the bromides and chloral, either administered by the mouth, by the rectum, or hypodermically, as the circumstances require, are the medicinal agents which have the best reputation, and which, in these cases, sometimes successfully depress the reflex irritability, and thus alleviate the symptoms. Blisters, the application of chloroform, ether, and of the faradic current to the epigastrium, of the ice-bag to the dorso-lumbar region have been tried and have afforded relief in some instances.

The resort to local treatment is indicated in all those cases in which a morbid condition of the uterus has been made out. Retroflexion and retroversion are to be corrected, and, if necessary, the uterus is to be retained in position by a suitable pessary. A congested vaginal portion may be relieved by scarifications, while the application of carbolic acid, or of a 10 per cent. solution of nitrate of silver to the eroded cervix will often prove successful in mitigating the distressing symptoms. Faggard\* states that in Vienna a 10 per cent. solution of nitrate of silver is employed in all cases of severe vomiting, irrespective of the condition of the vaginal portion. "The weight of testimony in favor of this simple procedure, collected from innumerable sources, is so great

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\* l. c



as to make its employment absolutely obligatory before resorting to more radical methods."

Dilatation of the cervix—Copeman's method—has proven successful according to some writers, while others report negative results. In the only case of severe vomiting which I have observed it had a most remarkable effect. The nausea disappeared instantly, but only for a few hours. The method was again applied, but no result was obtained the second time.

Horwitz† recommends that in the severer cases of vomiting the patient should be placed at rest in bed in the horizontal position, that the room be darkened, and that, if the stomach rejects everything, rectal alimentation should be resorted to. Crushed ice to quench the thirst is allowable. I can fully endorse this plan.

When these various methods have failed, when the vomiting actually is uncontrollable and seriously endangers the patient's life, the induction of abortion or premature labor is indicated, and will, if done in time, to a certainty save the woman.

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## ONE HUNDRED CONSECUTIVE CASES OF SKIN DISEASE.

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### VIII.

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By M. B. HUTCHINS, M. D.,

Lecturer on Diseases of the Skin, Atlanta Medical College, Atlanta, Ga.

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#### EPITHELIOMA.

In the hundred cases of skin disease there were two cases of epithelioma.

First, on arm of gentleman aged 67. Growth was situated on flexor surface left forearm, and began several months previously as a "pimple," irritation of shirt wristband gradually pro-

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† l. c.

ducing condition to be described. There was a raised, hard infiltration, confined to the skin, circumscribed, size of the finger nail and of reddish color. In the centre was a rather "sharp cut," deepish "ulcer," size of a pea, secreting a little thin, serous fluid, and showing a few dilated vessels in base. A small, hard papule just inside upper border. A few months later ulceration had ceased, but the growth continued to enlarge, retaining the characteristic hard, waxy border. Finally the epithelioma was excised by the patient's family physician, and it is scarcely possible that there will be a recurrence.

Second case was that of a gentleman aged 60. Disease situated on right side of neck along line of contact of collar. Began nine years preceding as a "little chafed place." When first seen by me the growth was about the size and shape of a finger, transverse to the neck, and formed of hard infiltration of the skin, of waxy appearance. At points it was papillary (the papular growths possessing the characteristic hardness); in other parts there were to be seen, at intervals, ulcerations elliptical in shape, base covered with "blood" crusts, edges hard; seat of destruction bled easily. Sensations were of tingling and itching. No involvement of lymphatic glands. On right cheek was a round, infiltrated, scaly lesion, and on left side of neck a somewhat similar formation, neither larger than a finger nail. Excision of growth on neck was advised, but the patient, so far as I know, has never had the operation done, being content because he found that the growth was looking better since it had been protected from rubbing of collar. The general health of both these patients was robust.

#### VARICOSE ULCER.

There was only one case of this "trouble." Patient single woman, employed as house-keeper, age 35. On left leg, just above ankle, inner side, two superficial, irregular, thinly-crustured ulcerative lesions, surrounding skin pigmented. Patient made the remarkable statement that this condition had been present "off and on" since she was thirteen years old! All the superficial veins of this leg and the foot were enormously dilated,

patulous, and some felt hard and resistant. There were extravasations in skin of instep.

Ordered to keep leg well bandaged from toes to knee, discard the garter, keep foot elevated when possible, and keep the ulcers wet with

R. Ichthyol., 3i.  
Aqua, ʒiv.

M.

There was steady improvement. Later, when there was only a little "tenderness," and slight crusting or scaling, the treatment was varied by the use of

R. Ichthyol., gr. xv.  
Ungt. zn. ox., ʒi.

M.

Under this treatment the ulcers were thoroughly healed, despite the terrible condition of the veins and the patient's unalterable conviction that the ulcers were the result of "blood disease."

While in the Skin and Cancer Hospital in New York I saw this plan invariably succeed, and have further proven its efficacy in cases treated in the "*second hundred*."

#### TINEA VERSICOLOR.

The only case of this disease was that of a medical student aged 23. Disease began ten years before, and in the past two years had rapidly involved the whole upper part of chest. There was evidence of the disease having formerly been in discrete patches, but now these patches had formed a confluent covering of the surface. Around borders were still to be seen separate small, typical maculæ, probably marking further spread of disease. Affected skin normal in thickness, patches yellowish in color, becoming red when rubbed. Thin branny scales easily rubbed off. Itching when patient became heated. A recent attack of measles had no apparent effect on the disease. Has never been treated. Under the microscope the scales were seen to be almost entirely composed of the fungus known as "*microsporon furfur*"

Patient was directed to "scrub" affected surface well with plain soap and water and then apply

R. Hydrarg. bichlor., gr. xx.  
Glycerin, ʒii.  
Sp. vin. rect.,  
Aquæ, aa ʒii.

M.

I did not see the case again, as patient left the city in a few days.

#### SCLERODERMA.

The one case of this disease was published in the JOURNAL last year.

#### SYCOSIS.

Of "true," or "non-parasitic," sycosis there was one case— young man of 28. Duration, "better or worse," five years. On left cheek in beard, in hair back of neck and on upper lip inflammatory papules and pustules each pierced by a hair and surrounded, or separated from each other, by healthy skin. (The above description gives, "in a nutshell," the diagnostic characters of the disease.) Later there were a few "abortive" lesions outside the hairy area.

An ointment with three per cent. ichthyol had no effect. Epilation of hairs involved was practiced from the beginning of treatment. Disease gradually declined under bathing face in water, to which patient was directed to add a little bichloride of mercury (he had access to, and knowledge of, drugs), and the use of

R. Hydrag. bichlor., gr. i.  
Sp. vin. rect., ʒii.  
Ungt. zn. ox., ʒi.

M.

Treatment was concluded with

R. Acid. salicyl., gr. x.  
Ungt. diachyli, ʒi.

M.

Discharged, well, in a month. Some months later there was a relapse, which I did not treat.

#### NÆVUS VASCULOSUS.

One case, little girl of 6 years. Beneath right orbit a horizontal, small straw sized dilated capillary, half inch long and radiating from this short capillary branches, all the vessels arterial red. (This corresponds to the old "nævus araneus," or "spider nævus"). Her father said the nævus had formed within the year. Destruction by electrolysis was advised, but the patient did not return.

#### CARCINOMA CUTICULARE.

This case was published in *New York Journal of Cutaneous and Genito-Urinary Diseases* in May of this year, and reprinted in this JOURNAL for July.

#### ERYTHEMA MULTIFORME.

Of this disease there was one case—that of a physician age 34. Duration four months. On forearms, wrists, thighs, at occipito-cervical junction, glans penis, abdomen and lower legs were grouped or solitary papular lesions, yellowish in color, average size small finger nail. Some were in rings. Some of the rings had coalesced to form gyrate patches. Older lesions slightly scaly; the yellowish or fawn color marked in all. Larger were depressed in the centre, the depressed part paler than the border. Sensations of slight itching. At beginning the patient had poor appetite, with "slight chilliness and fever at night."

Ordered to continue internally his own prescription of iron, quinine and strychnine and to paint the lesions with (the now familiar)

R. Picis. liq., 3i.  
Ether sulph.,  
Sp. vin. rect., aa ʒss.

M.

When, at end of three weeks, patient was seen, the eruption

had disappeared. Had relapse later, which got well under same treatment in two or three weeks. No recurrence since.

#### MOLLUSCUM EPITHELIALE.

The records of this case are not complete, as the patient returned to have treatment finished up after an absence of about eight months. As the disease is one of considerable interest, this case will probably be reported in detail when the treatment is finished.

#### "CINDERS IN SKIN."

This descriptive title was given to the case of a railroad man who had been thrown upon his face in a heap of cinders, in an accident. The skin around and above the right orbit was injured by the cinders, and particles were embedded which remained after healing of wounds, producing blue-black discolorations like tattooing. From time to time inflammatory action would take place, causing extrusion of some of the particles, Nature's effort at cure. A few of the colored lines were treated by an effort to imitate Nature. A silk thread was passed through the length of the line, tied and left to produce all the suppuration possible. The effect was much as desired, but the patient became annoyed with the threads and discontinued their use.

It was found impossible to pick out the deeply embedded particles without leaving an ugly scar. Two or three of the discolored lines over the orbit were excised, and also a large and very disfiguring "spot" in the soft skin of lower lid just at margin of orbit. Here a triangular piece of skin, one-third of an inch from point to point, was removed and the edges of the wound so brought together as to entirely prevent ectropion.

The excised skin was hardened in alcohol and sections for microscopic examination were made. The minute cinder particles were found thoroughly incorporated in the connective tissue of the corium, as if they were a part of its structure, showing how futile would have been further attempts at "picking out."

#### VERRUCA-WARTS.

The case coming under this head was that of a little negro having a palm-sized patch composed of closely set warty growths

just below the left knee. I think this case of sufficient interest to be published later, together with some cases in which the warty growths were also prominent, but will say a complete cure was made in a month with

R. Acid. salicyl.

Sp. vin. rect.

M. Ft. *Solutionem saturatum.*

Sig.—“Paint” on and let dry. Then rub in.

(*Xeroderma pigmentosum, etc., next article.*)

1½ *Edgewood Ave.*

**SPRAINS AND RHETORIC.**—The man that will give to the world an unfailing remedy for sprains shall have his name writ high upon the wall of the temple of fame, and his praises shall be sung through long ages by the bards of a grateful humanity.—*Med. Record.*

Medicine is the noblest of professions ; the meanest of trades. Unless you can live lives of purity, of virtue, of honor, and of honesty, seek a livelihood elsewhere, and insult not the gods by striving through base methods and ignoble ambitions to resemble them.—*T. Gaillard Thomas.*

From a private communication we learn that for some reason or other, climatic, meteorological, or sociological, the section of country around Rock Rum, Alabama, is not very conducive to large families. The cause of midwifery is languishing from disuse. The people do not obey the divine injunction, to be fruitful and multiply. At any rate, the children seem to be very unevenly distributed. One gentleman is the proud father of twenty-eight children, and our informant tells us that he looked as if he might continue to multiply and replenish the earth for many years yet.

## Society Reports.

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### GYNECOLOGICAL AND OBSTETRICAL SOCIETY OF CHICAGO.

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REGULAR MEETING, APRIL 17TH, 1891.

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The President, W. M. JAGGARD, in the chair.

DR. T. J. WATKINS read a paper on

#### LACERATION OF THE ANTERIOR VAGINAL WALL, AND ITS REPAIR.\*

DR. HENRY T. BYFORD: The operation, as performed by Dr. Watkins, is, I think, a remarkably useful one. It happens that the same shape of denudation was hit upon by myself and put into the last edition of Byford on "Diseases of Women," viz., a vaginal strip taken from each sulcus or each urethral notch and carried back. At the same time I describe the method of catching in the fascia so as to draw up the edges and attach them, giving them fascial attachment. In case it becomes necessary to shorten the anterior vaginal wall antero-posteriorly, a transverse strip can be denuded between these two. The method of putting in these sutures is also illustrated. I have no doubt Dr. Watkins' whole method is original, and there is one part that makes it more efficient, viz., extending the denudation straight back to the cervix. I have operated enough times to have had a good deal of trouble, and have had to give a good deal of thought to the subject of curing anterior colpocoele and cystocoele, and I know that whatever procedure we adopt the

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\*See original article, page 385.



condition is apt to return. I have denuded a portion from either side, where the sulci run into the little notch on either side of the urethra, and have carried the threads up behind the symphysis and out through the abdominal wall. That was all right; there was a good cicatricial contraction. But after a while the anterior wall comes down from further up nearer the cervix, and the loose tissue commences to protrude below the place that I have fixed up so nicely. So it struck me that Dr. Watkins had hit the nail on the head when he went back and took all the lateral tissue off—didn't leave any to come out. We know that even in virgins the uterus will come down with the vagina, and I wonder whether, unless the doctor takes out a good, wide strip from each posterior sulcus clear back, the uterus, not being firmly attached, will not push it all down again. We know the fascia about the cervix is quite loose when the cervix is down or well forward. The fascia, that passes on either side of the cervix through the broad and sacro-uterine ligaments, makes good points of attachments when it is firm, but when it is relaxed there is nothing to fix the vagina to the other end. So I am anxious to know whether this is, in such cases, a permanent cure. I have often been rather discouraged and wondered what we could do. I have taken out a good deal of vagina in front and behind, and have often found, after a few months, as much tissue there as before, peeping out triumphantly.

DR. J. ALEXANDER LYONS: I had the pleasure of assisting Dr. Watkins in the first few of his operations on the anterior vaginal wall, and the immediate result was so beautiful, and, indeed, so far as we can at present find out, so permanent, I feel like saying it is the operation that should be adopted on nearly all occasions for the relief of the vesical symptoms he has enumerated.

I have made the denudations, as he directs, on three patients with good results; seven months have elapsed since my first operation, but in no case has there been a return of the vesical symptoms.

One of my cases was a patient on whom a friend of mine was doing trachelorrhaphy and perineorrhaphy. I noticed there was

also a marked prolapse of the anterior vaginal wall, and suggested the Watkins operation. The doctor kindly allowed me to perform it; primary union followed, and the vesical symptoms, which the patient complained of before the operation, were relieved, although the perineum did not unite. I suppose union failed in the perineum because of septic discharges lying there, which would not be so likely to disturb the anterior wall.

DR. F. H. MARTIN: I would like to say a few words on this subject. I came here laboring under a slight delusion, as my impression, from the statement in the notice of the meeting, was that the operation was not only for laceration of the vagina, but for relaxation of the walls from any cause. The anterior vaginal wall is a hypotenuse of a right-angled triangle, the base of the triangle being represented by the pubes, the other side of the triangle by tissues from the superior margin of the pubes near the spine or in the region of the insertion of the round ligament to a point near where the anterior vaginal wall joins the cervix. The side of the triangle formed by the anterior wall of the vagina is considerably longer than the other long side, and forms with the utero-sacral ligaments a strong support spanning the entire pelvis. In case of pressure from above, long continued, the recto-uterine ligaments stretch, and the upper angle or the apex of the triangle is lowered, thereby causing necessarily a sagging in the anterior vaginal wall. In those cases where there are no lacerations of the vagina, and in cases of cystocele where childbirth may never have taken place, or, in a word, in old hospital cases, occurring in scrubwomen, washerwomen, etc., caused from pressure of the abdominal walls on this support across the pelvis, causing curvature in the anterior vaginal wall and the crowding of the bladder after it, operative interference is required as certainly as in those caused by lacerations. The anterior vaginal wall is made up of the vaginal layer of mucous membrane, which is thick and develops in case of pregnancy, and sometimes remains hypertrophied or in a state of subinvolution. Next to this we have the muscular coat, which is a continuation of the middle coat of the uterus, which of necessity becomes hypertrophied in cases of pregnancy, and which may re-

main in a state of subinvolution afterward, but which in its normal condition lies in folds, so that it throws the mucous membrane into transverse rugæ. The inner coat is composed of connective tissue, and is directly connected with the fascia of the pelvis, as stated by Dr. Watkins. Now, if we have a laceration of the anterior vaginal wall causing a cystocele, if we have subinvolution of the anterior vaginal wall, or if we have the condition of stretching that I have mentioned, in which we get hospital prolapse, we should perform almost an identical operation. That operation should not have for its object the removal of tissue, because ordinarily we have no more tissue than the Lord put there. If hypertrophy has occurred, it is not necessary to remove the tissue, but by properly distributing it we can restore the parts to a proportionate condition of health, and involution will do the rest. I have been very much surprised this evening to find that Dr. Watkins has described, in many respects, an operation which I have performed for these three conditions for a number of years, but in which I think I have adopted one or two procedures of advantage which he has not mentioned. I have made a drawing, and here I present a model out of a glove to represent the method of operating. In the first place, I have recognized the fact that the deep tissue should be reached instead of the muscular and mucous coats alone. I have made an elliptical denudation of the mucous membrane, very narrow in the same location that Dr. Watkins has described; after making this denudation, I dissect under the edges of the undenuded tissues laterally, so as to be able to get a larger freshened surface than the narrow denuded surface would allow otherwise, and be able to reach the deep fascia on either side with my buried stitches. I seek, in my operation, to narrow the vagina laterally by narrowing the fascial coat, while I care for the superabundant muscular coat of the vagina by throwing it into its original condition of transverse folds. When this is accomplished by means of the peculiar insertions of the buried catgut, the edges of the mucous membrane are in apposition, ready to be sutured with simple superficial stitches. I accomplish the results described by a peculiar method of inserting the buried stitches. Each portion of

catgut is inserted so as to have four points of traction, each point of insertion constituting one of these points; and when the quadruple stitch is tied it brings the four points in apposition. The upper two of the four insertions are deep and include the fascia; the lower two are more superficial, including the muscular coat alone.

DR. KARL SANDBERG: I was very favorably impressed with the operation devised by Dr. Watkins, and certainly consider it a great improvement upon the earlier methods of performing colporrhaphy—the old method, I might say, of making denudation in the middle and always of a certain form and with the sutures tied together in the middle. Dr. Watkins has devised this operation with the idea of the fascia being lacerated along the sulcus of one or both sides, all the way from the uterus down to the urethra. There is a little doubt in my mind whether this operation could not be still further improved; it seems to me to be schematized a little too much. I noticed in the list that out of twenty-three cases twenty-one were bilateral. I believe that by further experience this bilateral operation will be limited to fewer cases. I think that while the operator in the beginning may be afraid of overlooking any lacerations, and to be safe makes the operation extensive, the experienced eye or finger will be able to detect just where the laceration is and limit the operation to this point. It seems a little unreasonable that twenty-one of these twenty-three cases should have a laceration on both sides of the vagina extending all the way from the cervix uteri to the urethra. In regard to denudation, I should agree with Dr. Martin that it is absolutely unnecessary to remove any part of the mucous membrane; there is no superfluous mucous membrane; there is nothing to be removed. If we only make a vaginal incision and dissect up a little to each side, we will find the separated ends of the muscle, and we can bring them together and thus make the operation easier. It is reasonable to suppose that as well a small laceration of the cervix uteri may cause a subinvolution, or rather loss of contractile power of the whole organ; so also a subinvolution of the vagina or pelvic floor may be caused by a laceration of only a small part of the same. If this

supposition is right, then, in order to remedy the trouble, it would be necessary only to find this place and bring the lacerated parts together. If we can only develop our diagnostic faculties so far that we can put our finger on the spot and say, "There is where the laceration has occurred; this is the direction and that is the extension of the same," then, and only then, can we expect to perform a colporrhaphy intelligently, and until we reach this point we will be making extensive and multiple operations; so be sure to take in every possible laceration, and do not attempt to remove superabundant tissue that does not exist. There is undoubtedly in the matter of colporrhaphy a vast field for research yet, and while Dr. Watkins' operation is certainly a help in the right direction, I think there is still room for improvement.

DR. BANGA: I would like to ask Dr. Watkins how long after the operation he had seen the patients when he marked them down as cured. I would also ask whether, in preventing prolapse of the anterior wall, he considers emptying of the bladder during parturition as apt to prevent it; and I would like to know whether he has the urine drawn after the patient is put back in bed; also whether he puts the patient in prone position or allows her to lie on the back.

DR. T. J. WATKINS, in closing the discussion, said: The greater frequency of cystocele among workingwomen is due entirely to their mode of life. After confinement they are unable to take the time of rest necessary for involution. The character of their work also tends to produce cystocele. The more or less continued tension on the anterior vaginal wall excites a plastic exudate which bathes, softens the connective tissue and permits it to stretch.

The amount of tissue which should be removed in operations upon the vaginal canal is important. In order to get deep and firm union it is necessary to either fold the tissues upon themselves, or to bring them together by the method of flap-splitting. I do not see how this result can be obtained simply by sutures, as suggested by Drs. Martin and Sandberg.

The removal of the amount of mucous membrane suggested in this operation cannot be harmful, for the vaginal mucous mem-

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brane will stretch to almost any extent, as illustrated in complete prolapse of the uterus.

Dr. Martin evidently mistakes the object of the operation. The greatest objection to the median operation is that it shortens the anterior vaginal wall. This wall should be from two and a half to three inches in length, and the nearer we can keep the cervix to the sacrum the better will be the result.

In the cases which I have reported as cured, this term applies to the relief of symptoms and the removal of the mechanical indication for the operation.

I did not speak of the emptying of the bladder during labor, because it is a well established obstetric aphorism.

During the last two years I have paid particular attention to the prevention of the engagement of the anterior vaginal wall between the head and the pubes, and have never experienced any difficulty in accomplishing this.

I have avoided the use of the catheter in these cases as far as possible, on account of the risk of cystitis.

I have hitherto paid little attention to the patient's position during convalescence; the position suggested by Dr. Banga would probably diminish the tension on some of the sutures.

The denudation about the urethra is similar to that recommended by Dr. Byford.

When cystocele occurs in a virgin it is due to the constant tension and the plastic exudation as described above. Of course, the causes for the constant tension are various and often hard to determine. When the anterior vaginal wall is restored it is most essential to restore the proper direction of the canal, because it partially relieves the anterior vaginal wall from the weight of the uterus; that is, when the vaginal canal has its normal direction, intra-abdominal pressure is lateral; when the posterior vaginal wall is torn, intra-abdominal pressure is largely in the direction of the canal.

Dr. Sandberg made a slight mistake as to the location of the laceration. Two cases of unilateral laceration were reported.

## ALLEGHENY COUNTY MEDICAL SOCIETY.

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SCIENTIFIC MEETING, JUNE 16, 1891.

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T. D. DAVIS, M. D., President, in the chair.

DR. BLUME: Vomiting of Pregnancy. (See page 400.)

DR. LEMOYNE: I agree with the doctor that in a great many cases vomiting is largely due to abnormal conditions of the parts. I had the same experience with obstinate vomiting in this condition, and found it often was relieved by the correction of some erosion or displacement, although I do not believe that that always caused the condition. The doctor has very wisely laid a great deal of stress upon the matter of careful examination of the parts where these conditions exist, with the view of ascertaining and removing any such abnormal conditions.

DR. LANGE: An excellent paper the doctor has given us. It deserves our thanks. It is very comprehensive and thorough, and there is nothing in it to which any one can raise any objection, except perhaps this—the rectification of displacements of the uterus during pregnancy by the use of pessaries. That, in my experience, is impossible. In an impregnated uterus, and perhaps in a uterus which is not impregnated, I think that it is beginning to be thoroughly understood that the pessary is a means of absolutely no value, sometimes of great discomfort, and occasionally of some danger. The only pessary which may perhaps be sometimes of service is the ordinary balloon pessary, a rubber globe which is ballooned up by inflation with air or water. This, in my experience, prevents the descent of the uterus in some cases. The stem pessary of Dr. Kinloch may also be an exception to the rule that pessaries are useless for uterine displacement. This can be used, of course, only in the unimpregnated uterus, and may deserve consideration in flexions. Among the remedies which the doctor has mentioned are the most valuable, but I fail to hear calomel. Calomel has been, in my expe-

rience, a most valuable remedy. In proof of this, I had a lady under my care who had twice suffered abortion at four months, at the hands of most eminent gentlemen in the profession, because of pernicious vomiting, and their conclusion was that she would die. At her third pregnancy, she and her husband again concluded that she would die, and she certainly looked like it. Her adipose tissue had disappeared, her muscular system had atrophied, her belly was distended and tender, she was blanched, her pulse was small and rapid, she had an elevated temperature, and her tongue was red and dry. I gave her calomel—one-eighth grain every three hours. In forty-eight hours she was able to retain some food; in two weeks she left her bed, still sick, still vomiting, but able, despite her vomiting, to take a sufficient amount of food to maintain life and improve her condition. That is one instance where calomel exerted a very marked good effect and this was not due to any organic disease of the stomach. Sufficient proof of this is the fact that before her pregnancy she was always well, and the same was true before her previous pregnancies. She is the wife of a druggist in this city. I give calomel frequently in the vomiting of pregnancy, but in the case related it strikingly exhibited its power. The doctor mentioned a remedy with which I have no experience in the vomiting of pregnancy, but of which I have heard much good. I have always understood that the introduction of that method belonged to a Pittsburger, namely, Dr. M. O. Jones, of Wylie avenue, who informed Dr. Marion Sims of it; the latter teaching it in Paris in 1870. I have always understood that dilatation of the cervix and the separation of the membranes a little way up, which is said to be a very excellent remedy for the ordinary sickness of pregnancy, is the method of Dr. Jones.

DR. DAGGETT: The doctor speaks of increased temperature being one of the symptoms of pernicious vomiting. Is that one of the signs which arise before death?

DR. BLUME: In my case, after about two weeks had passed fever commenced, and after another week had passed, the woman still in bed, her fever went up to 103 and remained at that height for several weeks, and this case recovered without any medicine



whatever, having nothing but absolute rest. She was in bed about six weeks.

DR. BATTEN: I have had too cases of severe vomiting of pregnancy. One was in the person of an unmarried woman. At first I could not imagine (she was supposed to be a virgin) what the trouble could be. She was emaciated and her eyes were sunken; after two or three days my suspicion was aroused. There was no fever. The case went on for two weeks under my treatment with all the remedies that I knew of, excepting local applications, and from the fact that the young woman made the request that I keep her mother in darkness as to the cause of the trouble, I was prevented from making any local applications. But after exhausting everything I returned to blackberry brandy and stopped all medicine; after giving her the second dose the vomiting ceased and she recovered after taking the remedy some three weeks. Another case I had in 1882. A woman had seven children and never had any vomiting whatever; in this case the vomiting appeared at the end of the first month and continued right along to the end of the fifth month, and all remedies seemed to have no control whatever of the trouble. However, at the end of the fifth month, after I had given up the treatment, she was not so prostrated as the other case. It was a twin pregnancy, and when that woman was delivered one child was fully developed and another was dead, having died evidently at about the fifth month, about the time the sickness left her. The dead fœtus was in the neighborhood of five or six inches long. The woman ran on to full time.

DR. CONNELL: One point the doctor alluded to, the use of nitrate of silver. My attention was first called to the use of this remedy by Dr. Jones, whose name has been mentioned, and I think to him belongs the credit of the introduction of nitrate of silver treatment. In the *Journal of the American Medical Association*, of two years ago, there was a paper written by a gynecologist or obstetrician of Washington, whose name I cannot now recall, and in reply to that, Dr. Jones gave his experience in the use of nitrate of silver, and alluded to having spoken to Dr. Sims about it. Dr. Jones used that many years ago, and it is only a

few years since the attention of the profession was called to it. I have used it and had better results with the application of the nitrate of silver than with any other remedy.

DR. HUSELTON : I want to say a word in defence of the pessary. I think we have displacement of the uterus in the early stages of pregnancy. I also believe it is possible to rectify them and maintain them in proper position by the use of Thomas' retroversion pessary. I have certainly replaced retroverted uteri and maintained them in position with this pessary. With regard to treatment, as has been properly stated, I do not know of any one remedy that will relieve all cases. I remember one very aggravated case I had a number of years ago, in which I tried everything that I could think of, which I afterwards succeeded in relieving entirely with a large dose of chloride of potassium.

DR. GREEN : I have no criticism to offer on the paper. I wish to relate a case of vomiting during pregnancy which came under my observation on the sixth of this month. The lady was three month's pregnant. She had been treated by two or three physicians previous to her application to me. I do not know what remedies she had taken, but no relief had been afforded by any of them. I found her very much prostrated, and for five or six weeks she had had difficulty in retaining food sufficient to afford nourishment ; she had not rejected all the food and was still able to go about. An examination of the uterus discovered it to be displaced, retroflexed and apparently bound down with adhesions, and abortion was about to take place. There was evident hemorrhage, which had begun some time the previous night. She miscarried on the second day after I saw her. Again, I wish to say a word in regard to the use of the pessary. Whilst I have no doubt that the pessary may in certain cases do some damage, I have seen what I supposed was benefit, what I supposed was very great benefit, in the use of the soft pessary ; especially in cases coming under the class where displacement can be assigned as the cause, I have seen permanent relief. I wish to say a word about the damage sometimes done by pessaries. About six weeks ago I delivered a lady at term. On making examination, I found a common ring pessary, hard rubber. I said : "How long

have you worn this?" She replied, "About five years." Six years previously she had given birth to a child and immediately after that this pessary had been placed in the vagina and remained there ever since. I removed the pessary, and saw that it had done no harm. This, I presume, does not very often occur. It shows that the pessary does not always do very great damage.

DR. WERDER: I have no personal experience in this matter. I have had a large number of pregnant women under my observation, but have never seen a case of serious vomiting of pregnancy. There is no doubt that vomiting of pregnancy is a reflex neurosis—of course that is not saying very much—but I think in a large number of cases it is a form of hysteria. A number of cases have been reported which were treated as hysteria and got well under that treatment; before that, other methods of treatment were employed without any benefit whatever. I think there is no doubt that a large number of cases are hysterical in their character. In regard to pessaries, I have no doubt that pessaries are used very much, and very many women would be far better without them, but there are exceptions to that. I think a good many women would not feel comfortable without the pessary. If the uterus is properly replaced and in normal position and a pessary is introduced, where there is no inflammatory condition of the pelvis, in many cases it does a great deal of good. Many of these women are very comfortable wearing a pessary for months, and women come to me with pessaries where there is no flexion at all, where there is no displacement of the womb, and sometimes there is a displacement, but it has not been reduced at all, the uterus is retroflexed just the same as it was before the pessary was introduced. In pregnancy I have had probably two or three cases of this class, and am certain that these women suffered before the uterus was put in position and before the pessary was introduced, and the benefit they derived from the pessary was also very great.

DR. DAVIS: Dr. Blume certainly covers the ground in every particular very thoroughly, and there is one point that he dwelt on and that is, as he said very aptly, you would think that the diagnosis of pregnancy was a very easy thing, and yet I believe

this is an important point of the question for discussion to-night. I believe that on that hangs the treatment, and that is the reason why such various treatments are recommended, and why in some cases one treatment acts very favorably and another treatment is of no benefit. I think it stands to reason that if pregnancy is the cause of this vomiting, calomel would have very little effect. I think it stands to reason that if there is no (or very little) trouble of the uterus, but if there is a disease of the stomach, calomel would be very beneficial. And therefore, while in one case I would expect benefit from it, in the other, it would be *nil*. On one occasion I was called to see two ladies, neighbors, both suffering with morning sickness of no aggravated form, but enough to give them great discomfort. To the one I prescribed to the best of my judgment what was wanted, bromide of potash. In the other I prescribed hypophosphites in an acid solution. I remember distinctly they were given in quite large bottles; they each used about half of the bottles, which were given within a day or two of the same time, and were none the better, but rather grew worse. Talking, as neighbors will do, over the back fence, they compared notes and traded bottles, and in a very short time both were completely relieved. The explanation is simply this, that the acid and the hypophosphites in the state of the one stomach was just what was needed, while the nervine and the alkali was just what the other needed. I believe that as far as we possibly can we ought to ascertain what is producing this particular sickness in this particular woman, and not take it for granted that all morning sicknesses are from identically the same cause. In my experience I have seen a great many severe cases. Pregnancy acts differently in different persons, and the thing that would remedy one case would be useless in another. I have seen a good many that I considered very severe cases, but it has been my lot to see one that was of unusual severity, at least the result shows it to have been so.

A lady of whose medical history I know comparatively little came under my observation for four visits. She was several months gone in pregnancy and was suffering with profound morning sickness. A particular characteristic of it, as I noticed

in these four visits, which extended over about ten days, was pytalism. In fact in my presence she was so overcome that she had to vomit. As I was seeing the case in connection with another physician, a friend and relative, who had been there about an hour before my last visit, I did not push the investigation at that time as I had no particular alarm. That was on Thursday evening. It had been the case for the husband to drop in to tell me how she was feeling, and to telephone if she was feeling unusually bad. Thursday evening I saw her last. Sabbath morning the physician dropped in and told me he had called and found her in a very critical condition. It seems that on Friday morning a lady physician had been called in, and on Friday and Saturday had seen her in this condition of increasing irritation of the stomach, and vomiting of some cloudy fluid, and on Sabbath morning when her friend, the physician, saw her, she was in a critical condition, and in spite of dilatation and everything else that could be accomplished on Sabbath night, she died on Monday. I felt impressed at the time and more impressed upon hearing Dr. Blume's paper to-night, that a *post mortem* examination should have been held on the case.

DR. KOENIG: It seems to me that in looking for a specific cause of vomiting in pregnancy we overlook the fact that the nervous system is very powerfully affected by the pregnancy itself. Vomiting in pregnancy is so common that it cannot be due to a gastric lesion; it must depend on an irritation of a nerve ganglion that transmits it to the brain. It has been said that it is impossible to explain why the peculiar motion of a ship should produce vomiting; I have never heard it explained; I do not suppose we can explain it, nor can we explain satisfactorily how the vomiting of pregnancy is produced. It would appear to me that the action of all remedies that are of any value can be accounted for in two ways, one a counter-irritation, which would explain the action of pessaries; explain the action of nitrate of silver when applied to the os; and would explain the action of dilatation. By these an irritation is produced which diverts the attention of nature from the disturbing causes which produce vomiting. The artificial irritation at the os distracts

the attention of nature from the other point of irritation, and the vomiting ceases. The other action to which I refer is an anæsthetic action applied to the terminal nerve filaments of the stomach. I have recently seen a remedy, possessing this action, recommended, which Dr. Blume did not refer to in his paper, namely, menthol in two grain doses. Menthol is a powerful anæsthetic, and by deadening the sensibility of the nerves of the stomach I can very readily conceive how the vomiting might be arrested. We all know the tendency of disease is toward recovery, and if vomiting in pregnancy is a disease, it is especially true in this case. The fact accounts for the numerous remedies that are said to be corrective. That fact might account for the results that followed the exchange of remedies in the case alluded to by the President. A large majority of cases recover without medication.

DR. DUFF: I would make the distinction in discussing the subject between simple vomiting during the ordinary morning sickness of pregnancy, the more persistent and aggravated vomiting, and the pernicious vomiting. There is a conservatism of nature in the first class; indeed, some observers declare this to be so. inasmuch as women thus affected go through their pregnancy, as a rule, better than do those who are not. The pernicious vomiting, due entirely to pregnancy, without complication, is, I think, a rarity. The failure up to this time of observers to agree upon any common cause of vomiting during pregnancy, is *prima facie* evidence of varying causes. Our treatment, therefore, should depend upon a rational consideration of each case presented to us. In the cases of Dr. Davis, I do not think that when the exchange of medicine was made the patients were about to get well. I think the exchange was a happy one, inasmuch as the then treatment was in accordance with the acid or alkaline condition of the secretions. I did not notice that the doctor said anything about electric treatment. I think it is sometimes efficacious. Another mode of treatment is the application of cocaine to the cervix uteri. Injecting it into the tissues of the cervix, I think, gives the best results, although painting with a 15 per cent. solution may answer as well.

DR. BLUME: It has been said that pessaries should not be employed to retain a gravid uterus which has been retroflected. Vomiting, as a rule, occurs during the first few months of pregnancy; the replaced uterus will, at so early a period of gestation, often need a support or become again retroflected. We have two means to retain the uterus in its normal position: 1st, Tampons; 2d, pessaries. Tampons must frequently be changed, are therefore inconvenient and even injurious, as they may incite contractions and thus produce abortion. A suitable pessary does no harm, under these circumstances, as I have seen in many instances. Stem-pessaries cannot be considered here. In my opinion they should never be used. They are certainly contraindicated during pregnancy.

Calomel has not been mentioned by me, because it failed entirely to influence the gastric disturbances in my cases. It acts as a simple purgative, and is indicated or may be tried in cases complicated with costiveness.

Gastric medication is applicable only in the milder forms of vomiting. Cases of pernicious vomiting, where everything is rejected by the stomach, cannot be relieved by drugs, be they given by the mouth, by the rectum, or hypodermically. It may sometimes be possible to stop the vomiting for a few hours, but, as a consequence, the nausea becomes so intense that the patient feels relieved as soon as the vomiting commences again.

One gentleman said that dilatation of the cervical canal has been practiced many years ago. This method, first recommended by Copeman, justly bears his name, Copeman's method. Dilatation of the cervix, if carefully effected, does not interrupt pregnancy. But if the internal os is dilated, or, as one gentleman recommended to-night, if the membranes are detached around the internal os, abortion will probably be the consequence.

The view, expressed by one gentleman, that patients with the ordinary vomiting do better at term than those without this disorder, is at least surprising and by no means supported by experience.

In conclusion I wish to touch a point which I have not discussed in my paper, viz.: When has the vomiting become uncontrolla-

ble, and when is the induction of abortion indicated? This question is a very important one, for if we wait too long the woman will in all probability lose her life. Uncontrollable vomiting is apparently very rare in our vicinity. The case reported by Dr. Davis is the only one I heard of in this city, and I regret that no autopsy has been made. In New York where this subject has been discussed in the Obstetrical Society, last fall, pernicious vomiting must be a rather frequent complication, as almost every speaker reported cases where artificial abortion had to be induced to save the patient. Several women died, the evacuation of the uterine contents having been too long delayed. All the speakers agreed that abortion should be induced before the condition of the patient had become critical.

I believe that no precise rules can be given as to when to empty the uterus, and that every case must be treated according to its peculiarities. When the various methods of treatment have been tried in vain, when the patient becomes more and more emaciated, it seems hazardous to wait for the most extreme degree of exhaustion. A consultation should be held and the induction of abortion, the last chance of saving the woman's life, should not be postponed too long.

DR. LEMOYNE: In December, 1890, I was requested to see a woman in consultation, who was supposed to be six and a half months pregnant. She has been delivered of two children at full term previously, and had one miscarriage at about six months. For about two weeks she had noticed some swelling of the lower extremities, and a specimen of her urine, which was procured the evening previous to my attendance, was found to be so largely composed of albumen as almost to solidify by boiling. She had taken her evening meal with her family, between six and seven o'clock, but while at the table experienced considerable pain in the abdominal region, and was compelled to retire before finishing. She was assisted to bed, and medical attention procured. Between that time and six o'clock the following morning she had three very decided convulsions. At six o'clock A. M., her expression was rather dull, but she responded



intelligently to questions, and recognized persons who addressed her. The mouth of the uterus was sufficiently patulous to admit the point of a finger, which readily detected the body of the foetus. No instrumental apparatus being at hand for the dilatation of the neck of the uterus, suitable appliances were immediately sent for. But the patient's condition, being such as to promise an early return of the convulsions, admitted of no delay, and dilatation was practiced with great perseverance and determination by means of the fingers. The success of this method was such that when the Barnes dilators and parallel steel blades arrived, the divulsion was beyond their capacity, but not sufficient to admit the hand. At 9 A. M., no relief being experienced and every moment seeming to endanger the patient's life, the long obstetrical forceps were resorted to with the intention of either grasping the foetus in their blades and forcing it away, or effectually dilating the mouth of the uterus by delivering the forceps in the locked position. The first mentioned plan failed, as no engagement could be procured; but with little difficulty the blades were successfully introduced, locked and gradually delivered, dilating the uterus sufficiently to enable the hand to enter, seize the thighs of a breech-presenting foetus, and accomplish its speedy delivery. Two modified convulsions occurred after the delivery, and five severe ones previous to it. The normal function of the kidneys was soon re-established, and a very satisfactory recovery soon followed.

I offer the history of this case, believing it to illustrate a very valuable and nearly always practicable method of dilating the uterus, and thinking that it may be new to others as it has been to me.

DR. DUFF: The simple introduction of the forceps through the os, locking them without grasping any portion of the child, and withdrawing them for the purpose of dilatation, it appears to me would be impossible except where the head was still above the superior strait, where there was the same condition in a breech, or where there was an oblique presentation. I have frequently introduced the forceps where the os was only dilated sufficiently to admit of their introduction with the double

purpose of dilating and of traction. I think Dr. LeMoyne's method justifiable.

DR. BLUME: If delivery of the head should be impossible, I think it is safest to turn by the hand and extract; a woman could be delivered in that way. I do not know in this case whether the child was living or not. I think we have other measures which should be tried first; for instance, anæsthesia.

DR. LEMOYNE: The dilating of the os, I stated in my paper, was done by physical means. I introduced my fingers, first one finger, and then another finger beside it, and finally two fingers and the thumb, until I reached a degree of dilatation that would admit the blades of the forceps consecutively. I also stated that, having no suitable instrument for the purpose when the case was thrust upon my treatment, I had to resort to natural means, and by the time the instruments arrived by which I expected to accomplish dilatation, I had already dilated to a sufficient extent with my fingers to introduce the blades of the forceps, and my diagnosis of the position being still uncertain, I introduced the forceps with the intention of seizing any part which might present. It strikes me as a very fortunate thought, and resulted certainly very favorably.

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AWAY WITH KOCH'S LYMPH.—I have given Koch's lymph a fair trial and have carefully observed its effects, and have become firmly convinced both of the danger which attends its use and its utter inability to cure any form of tuberculosis. In not a single instance of eleven cases of surgical tuberculosis that came under my own observation did the treatment result in anything more than a temporary improvement, and in several of them it was followed by local extension of the disease and serious impairment of the general health. The effect of tuberculin proved more serious in the treatment of the forty-three cases of pulmonary tuberculosis. There can be but little doubt that in a number of the fatal cases, death was hastened by the treatment, and that in a number of the mild cases it contributed largely towards the rapid local extension of the lesion; while the tuberculin treatment of pulmonary tuberculosis can show no better results, it is difficult to ignore the fact that it has been productive of more harm than almost any other plan of treatment heretofore suggested; and on this score alone the verdict "Away With Koch's Lymph!" is timely and imperative.—*N. Senn, M. D.*

## Editorial.

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### SOME REMARKS.

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THE voice of the medical reformer is now heard in the land. And it is the rights and freedom of that worthy class of American citizens, the doctor, that he wishes principally to modify or abridge. His usual habitat is in the legislature. Here in Georgia he proposes to make it a misdemeanor for physicians to get drunk. During the present session he nursed for a few days a measure over in the Capitol, requiring all Georgia Medical Colleges to inaugurate a three-year course. This infant, which deserved to live, smiled faintly at first, then gasped and died.

Out in Missouri also he is vexing his massive brain with the three-year course; is also struggling with the ever-present and ever-interesting matter of *prostitution*; and lastly, but not least, he proposes to limit physicians' fees to one dollar per visit, and fifty cents for office consultation.

In New York, not very long ago, the legislature made an enactment, which, putting it very mildly, has not been altogether an unmixed blessing. Now they propose to remedy all difficulties by giving the licensing power to the faculties of certain medical colleges. Imagine the passage of such a measure in New York! Compared with the confusion which would result, the alleged Babel incident would be a concord of sweet sounds; and Pandemonium a Quaker meeting.

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SPEAKING of medical legislation, cultured and cultivated Massachusetts deserves the warm congratulations of all lovers of

medical progress and reform. The comedians of her General Assembly have passed a bill—called a *law*, through courtesy—which requires simply and only a *register* to be kept of *all persons who desire to practice medicine in the State*. Really, New England must be coming to the front, and we suspect that ere long enlightened and hyperæsthetic Massachusetts will be in line with our esteemed and phlegmatic sister, Alabama.

We suggest to the funny legislators of the classic Bay State the following motto for their little bill, and pray the shades of Horace to excuse our liberties with his Latin : *Parturibant montes ; nascitur ridiculus mus*.

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THE latest sensation in medical and lay circles abroad seems to be the so-called *scandal* which has been considerably exercising the nervous Parisian mind of late.

It seems that as far back as four years ago, an enterprising surgeon (whose name is withheld for prudential reasons), imbued with an ambitious spirit of experiment, inoculated the healthy mamma of a female patient with a small portion of a sarcoma removed from the other breast. The inoculation "took," so to speak, and in two months a hard nodule, the size of an almond, developed. Sections of both tumors were submitted to Professor Cornil who pronounced them identical and composed of fasciculated sarcomatous tissue. Sometime after the second tumor was removed the patient died from some intercurrent condition, and the autopsy failed to show the existence of sarcoma in any other part of the body.

An analogous experiment was made on another patient with a cylindrical epithelioma, but the structure of the secondary tumor was not ascertained, as the patient refused to allow its removal.

These results were reported by Professor Cornil to the French Academy of Medicine in June. The *N. Y. Medical Journal*

remarks: "These experiments are obviously, when viewed from a scientific standpoint, of vital importance, and, considered in connection with recent researches on the parasitic nature of malignant growths, cannot fail to be of great use to future investigators. But morally no possible excuse can be found for such trifling with a precious human life, and the conduct of the anonymous surgeon in question fully merits the condemnation passed on it by M. Le Fort and M. Moutard-Martin, whose remarks were cheered to the echo by the members of the *Academie* present on the occasion. It is only just to add that Professor Cornil hastened to associate himself with the sentiments expressed by his colleagues, alleging that his sole motive in bringing the matter to the notice of his fellow academicians was a purely scientific one. The lay press was, of course, not behind-hand in indignantly protesting against such an inhuman proceeding. No one who has the privilege of knowing Professor Cornil, who is kindness itself, would for one instant entertain the belief that this distinguished pathologist had been actuated by aught but the most elevated humanitarian motives in making public—after a lapse of four years, be it said—the results of an experiment whose practical importance cannot well be exaggerated, however severely one may condemn the proceedings of its author."

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Dr. Mark O'Daniel, so long associated with the State Insane Asylum, has resigned his position, in order to resume general practice. He is now renewing his medical studies in New York, and upon his return will locate in Macon. As far as possible he wishes to make a specialty of nervous and mental diseases. Dr. W. A. O'Daniel, formerly of Macon, and Dr. Patterson have been elected on the house staff at Asylum.

## **Selections.**

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### **"THE SUPPOSED CURATIVE EFFECT OF OPERATIONS PER SE."**

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Under this title Professor J. William White, of Philadelphia, contributes a paper to the *Annals of Surgery* for August, 1891, which not only from its subject, but from the great number of authorities quoted and from the peculiarly rich experience of the writer makes an article of unusual interest and importance to both surgeon and physician. The author's attention was first directed to this subject by reason of his experience with the operation of trephining for so-called traumatic epilepsy.

During the past five years, with Dr. D. Hayes Agnew, he has trephined in fifteen cases of supposed traumatic epilepsy. All but one recovered from the operation. The patient who perished was an imbecile and a confirmed drunkard as well as an epileptic. Death occurred from suppression of urine probably secondary to etherization.

In one case a bullet was found imbedded in the brain substance, in another an irregular portion of the internal table was dissected out from beneath the dura mater to which it was attached by cicatricial adhesions. In another there were projecting spicules of bone on the internal surface of the button removed and the adjacent portions of the skull. In two marked sclerosis and thickening of the cranium were observed about the field of operation. In remaining cases nothing abnormal was seen. Although this was the case they were without exception markedly improved by trephining; in two instances even to the point of apparent cure, no return of symptoms having been observed for eighteen months, and for two years after the operation.

In the other seven the results were strikingly favorable, con-

vulsions disappearing for weeks or months, although previously of more than daily occurrence.

The author has, in so far as this is possible, classified the cases in which operation *per se* seemed to be the main factor in bringing about a cure. These cases are divided into three groups in accordance with the anatomical seat of the symptoms or of the supposed disease. This brings them under the following heads :

1. Operations for the relief of nervous phenomena, as epilepsy, insanity, paralysis, etc.

2. Operations for abdominal and pelvic disorders, as peritonitis, tumors, etc.

3. Miscellaneous Operations.

This classification is further carried out by grouping together, (a) Those cases in which nothing whatever was found explanatory of the symptoms. (b) Those in which some departure from normal conditions was observed, but was so slight as to be apparently inadequate to explain the symptoms. (c) Those cases in which an apparently grave and irremediable condition was disclosed by an exploratory operation, but notably improved or altogether disappeared after mere inspection or handling, no further surgical interference having been thought justifiable.

Under the heading of "Operations for the Relief of Nervous Phenomena," Dr. White had tabulated, including his own service, one hundred and fifty-four cases. Many of these are given in detail, and coming, as they do, from recognized authorities are of exceeding great interest.

In fifty-six cases of trephining for epilepsy nothing abnormal was found to account for the symptoms. Nineteen cases were reported in six months or less after operation ; eleven cases were reported from six to twelve months after operation ; six cases were reported from one to two years after operation ; one was reported eight years after the operation.

Twenty-five of these cases were reported as cured, eighteen as improved ; in three cases it was mentioned that a relapse occurred later.

In thirty cases of ligation of blood vessels for epilepsy fourteen were reported as cured ; fifteen as improved ; one died seven

days after operation. In the fatal case the right common carotid artery was tied. No fit occurred after the operation.

In ten cases of castration for epilepsy all were reported as cured. One case was reported four months after operation; four cases were reported more than two years after operation; in five the time when reported is not mentioned.

In nine cases of tracheotomy for epilepsy two were reported as cured; six as improved; one as much improved, though death in this case followed in two months after the operation.

In twenty-four cases of removal of the superior cervical ganglia of the sympathetic nerve six remained well at the end of three years; ten were improved; five remained unimproved; two died soon after the operation but not from its direct effects.

In six cases of incision of the scalp for epilepsy nothing was found to account for the symptoms. Three of these cases were reported as cured at the end of three months or less; one was reported as cured at the end of one year; two were reported as cured at the end of two years; two other cases almost similar were reported as cured.

Twelve cases of epilepsy are reported as cured by such operations as stretching of the sciatic nerve, excision of the musculocutaneous nerve, cauterization of the larynx, circumcision, application of a seton to the back of the neck, tenotomy of the external recti muscles, burning of the scalp, puncture of the heart, etc.

Thirteen cases of spontaneous or accidental cures of epilepsy are also reported, at a time varying from two months to five years after the traumatism, which was a fall, a burn, a wound, an amputation for intercurrent injury or disease, etc.

Passing from the cerebral to the spinal region, Dr. White cites an illustrative case of his own. A man, aged fifty-five, was attacked on December 25, 1887, with severe pains in his arms and shoulders. A few days later there was weakness of the thighs spreading rapidly down the legs to the feet, and upward on the body to the nipple line. In eight days there was absolute paralysis of the parts involved, including both sphincters, while at the same time the paralyzed parts became the seat of profound anæsthesia. Girdle pains developed, bed sores made



their appearance, percussion of the spine over the third and fourth vertebræ became painful. The reflexes were exaggerated, and light blows on the head in the direction of the spinal axis gave rise to frightful exacerbation of the girdle pains. In spite of every remedial measure these symptoms increased in severity for ten months. An exploratory operation was then undertaken. Dr. White removed the spines and laminæ of the first five dorsal vertebræ, opened the slightly thickened dura, separated some firm adhesions to the subjacent pia mater, explored the cord, and having failed to discover any serious pathological changes closed the wounds in the dura and soft parts.

The girdle pain had entirely disappeared by the following day, sensation began to return in the feet the day after, voluntary motion in the toes after the eighth day, and so one symptom after another disappeared, until the patient completely recovered and is now earning his living by manual labor.

In the list of abdominal and pelvic disorders apparently cured by operation *per se*, a number of extraordinary cases are cited. The experience of Tait, who has more than once drawn attention to the astonishing disappearance of tumors often of large size, after a mere exploratory incision, and the corroborative testimony of Von Mosetig are recited at length. Kœnig's analysis of one hundred and thirty-one cases of tubercular peritonitis treated by abdominal incision is carefully discussed.

In response to letters of inquiry upon the subject, Dr. White received many communications from prominent operators, the great majority of them containing notes of cases not previously published.

Among the signers of these letters are to be found the names Goodell, Hirst, Battey, Roswell Park, Lusk, Cheever, Chas. T. Parkes, Cabot, Hunter McGuire, Nancrede, Weir, Stimson, and many others of equal note.

Under the heading of miscellaneous operations, the author has given several of very diverse character.

First are quoted osteo-malacia, cured, after weeks or months of confinement to bed, by either oöphorectomy or Cæsarian section.

Passing to another subject the question of graduated tenotomy of the eye muscles for the relief of severe nervous symptoms is carefully discussed. The author freely acknowledges the value of tenotomies both complete and graduated in the restoration of equilibrium in badly balanced ocular muscles, but he is none the less convinced that in numbers of instances of reported cures of chronic chorea, petit mal, and even delusional insanity, the effect of the operation *per se* is in large measure the potent cause of the supposed cure. This belief is founded not alone on theory, but upon the fact that in certain cases of reflex nervous trouble a cessation of the symptoms has followed the tenotomy, although this has not produced perfect equilibrium. Again, the relapses which may take place after a perfectly successful series of tenotomies would indicate that the nervous phenomena attributed to the insufficiency, for the relief of which the operations were made, were not correctly so attributed, and that the temporary relief must be ascribed to some cause other than the restoration of an imperfect balance of the external ocular muscles.

In seeking for a reasonable explanation of the phenomena observed in the above cases the author has formulated the conditions which are common to nearly all of them. These are:

1. Anæsthesia.
2. Psychical influence, or so-called mental impression.
3. Relief of tension.
4. Reflex action, or the correction of traumatism.

These influences were operative in the majority of cases, although not one of them except the last applies to the whole list.

With the idea that it was conceivable that a disease of the nerve centres, not reached by ordinary drugs might be affected by agents of such volatility and diffusibility as ether and chloroform, the author instituted a series of observations upon a number of epileptics in various stages of the disease. All other treatment was withdrawn, ether was given to the production of full anæsthesia at intervals of from forty-eight to seventy-two hours. The results were either entirely negative, or in consequence of the withdrawal of their bromides, the patients grew worse.

Since in the great majority of cases upon which Dr. White bases his paper, there were either undoubted symptoms such as are habitually associated with organic disease, or there was demonstrable and unmistakable evidence of such disease, it is necessary to believe, in considering the psychical influence of operation, that powerful impressions, acting upon the emotional or intellectual nature, may affect the organic processes of secretion, nutrition, etc., and may arrest pathological changes and bring about reparative or recuperative action. Cases are cited in which such influences are clearly set forth.

The author holds that the normal equilibrium which we witness between the cerebro-spinal and the sympathetic systems, as respects their influence upon the blood-vessel, is obviously more or less interfered with, when the brain transmits a more than wonted impulse, allowing the unrestrained action, or paralyzing the influences of the sympathetic vaso-motor nerve. In this relation the author narrates some remarkable cases of hypnotism, and quotes some striking examples of the effect of the central nervous system upon the body.

Belief is expressed that in many of the cases described there can be little doubt that relief of tension is an important factor in amelioration or cure. If it is assumed that preternatural tension exists in the cranial cavity, this would be relieved to an extent by trephining, and there would be but few exceptions to the rule that in each case something was done which lessened tension in the cavity or organ of the body. There are other cases, however, in which no such relief was obtained, and yet cure resulted from operation. A diminution of the tension would manifestly alter the blood supply to any important organ in the body, and with it the nutritive processes local and general. Beyond this nothing definite can be said except as it applies to cases of ascites in which as, in cases of hydrarthrosis, i, tapping may prove permanently curative because the original source of irritation and hypersecretion has already disappeared.

Under the head of Reflex Action the author includes the "reaction of traumatism," as well as the effects of revulsion and counter-irritation.

Verneuil has long since shown that very slight traumatism sometimes excites in the entire economy a general perturbation, and sometimes, by selection of the weak point, a sudden aggravation of lesions that are only slight or have slumbered. This same excitement, usually prejudicial, may occasionally be curative. In the case of spinal surgery, above detailed, Dr. White believes that the local shock of the operation was promptly followed by a corresponding reaction, in which the vitality of the tissues was raised sufficiently high to determine a return to the normal state. In this relation the reciprocal influence of one portion of the body on another is briefly discussed.

In considering abdominal tumors attention is called to the possibility of the spontaneous disappearance of such tumors, the relation of this disappearance to the operation being coincidental; cases are cited in point. As to the cure or amelioration of growths thought to be malignant by merely exploratory operation, a long search through the literature of the subject has met with but little success.

The cure of tuberculosis of the peritoneum as the result of exploratory incision is explained on the ground that the removal of ascitic fluid allows the peritoneal surfaces to fall together, and to acquire adhesions. The tubercles are then shut in between the coils of intestine, the omentum and the abdominal wall. They are thus surrounded by tissues in a high degree of activity, which can now throw around them the limiting zone of young cells, and eventually fibrous tissue, which if the tuberculous process is not too far advanced may effectually resist it, and may cause it to retrograde, the process being analogous to that which we see imperfectly going on around a cancerous growth.

As a result of a study of the subject the author believes the following conclusions are warranted :

1. There are large numbers of cases of different grades of severity and varying character which seem to be benefited by operation alone, some of them by almost any operation.

2. These cases include chiefly epilepsy, certain abdominal tumors, and peritoneal effusions and tubercle, though the im-

provement in the latter is, perhaps, to be explained on general principles.

3. Of the possible factors which, by reason of their constancy must be considered, anæsthesia seems least likely to have been effective. The other three, viz., psychical influence relief of tension, and reflex action, may enter in varying degrees into the therapeutics of these cases, and taken together serve to render the occurrence of occasional cures less mysterious.

4. The theory of accident or coincidence scarcely explains the facts satisfactorily.

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THE ÆTIOLOGY OF DIPHTHERIA.—In the *Johns Hopkins Bulletin*, Dr. W. H. Welch gives the latest results of the researches on this point, and adds from his own studies still other observations. From all this he concludes it is fully proved that the specific primary cause of diphtheria is the Klebs-Löffler bacillus. This organism he calls the bacillus diphtheriæ. This bacillus is present in every case of primary diphtheria, in such number and situation as to explain the local manifestations of the disease. It can be isolated in pure culture readily, and a disease, identical in all respects with human diphtheria, can be produced experimentally by the inoculation of pure cultures.

Thus we are in possession of positive means for making a diagnosis of diphtheria. The method of doing this is not difficult and can readily be applied, though it may be questioned whether many practitioners are likely to make use of these means.

We are taught that there are pseudo-membranous anginas which must be separated from ætiologically pure diphtheria, and that diphtheria may exist in extremely mild forms even without visible pseudo-membranous deposits.

The endless controversy as to whether diphtheria is primarily a local or general disease is settled. It is primarily local, the grave constitutional symptoms are the result of intoxication with poisonous products, formed by the local action of the bacilli.

We can study the varied effects produced upon the animal body by the specific toxic products of the diphtheritic germ.

We can separate the alterations belonging to the disease itself from the many complications of the disease. Intelligent measures of prophylaxis can be based upon a definite knowledge of the characters of the specific germ and its behavior in the body. Rational indications for treatment can be established, and have been formulated.—*American Lancet*.

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### MEDICAL ITEMS.

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It is said that eleven physicians have found a specific for tuberculosis. The latest (by Max Schüller) is injections of iodoform, with the internal use of guaiacol.

The late Mr. W. A. Moore, of Atlanta, bequeathed \$7,500 to the Grady Hospital, on condition that the institution be maintained by the city government.

The third annual meeting of the Tri-State Medical Association will convene in Turner Hall, Chattanooga, Tenn., Tuesday, October 27th, 1891, and continue in session three days. Indications are that it will be one of the largest medical meetings ever held in the South. Representative physicians from all sections will be present.

All who desire to read papers should send title to the Secretary of the Association before September 1st. In due time a circular will be issued, giving a complete list of all papers and names of exhibitors who apply for space before October 1st.

W. L. GAHAGAN,  
Sec'y of Executive Committee,

P. O. Box 542.

Chattanooga, Tenn.

## Book Reviews.

**DISEASES OF THE NERVOUS SYSTEM.** By William A. Hammond, M. D., Surgeon-General U. S. Army (Retired List), late Professor of Diseases of the Mind and Nervous System, College of Physicians and Surgeons, New York, etc.; with the collaboration of Græme M. Hammond, M. D., Professor of Diseases of the Mind and Nervous System in the N. Y. Post Graduate Medical School, etc. Ninth Edition. D. Appleton & Co., New York.

Dr. Hammond's work on Nervous Diseases has too long been a classic to require extended review. It has been translated into several foreign languages, and is accepted as a treatise of great merit and authority wherever it is read. Some new chapters have been added in the present edition—on Acromegaly, Symmetrical Gangrene of the Extremities, etc. Several new plates and illustrations have also been inserted.

With the assistance of his son the distinguished author has brought his work fully up to date, and has disarmed adverse criticism.

**PRACTICAL THERAPEUTICS.** By Hobart A. Hare, M. D., Late Demonstrator of Therapeutics in the University of Pennsylvania; now Professor of Materia Medica and Therapeutics in Jefferson Medical College, Philadelphia, etc. Lea Brothers & Co., Philadelphia.

The author's apology for writing this work is his belief that "most of the text-books on materia medica treat of it as if the student were already a skilled physician or experimental pharmacologist." He states that his object is to furnish students with the *reasons* for the pursuance of a given policy under given conditions. This is a very laudable purpose, and throughout the book, and particularly in Part IV., we find it very well sustained. The department of Therapeutics proper is something more than a list of diseases with an annexed list of drugs which have been tried in the treatment of the same—it is an intelligent, but brief, description of the rational application of remedial agents. However, we cannot but question the application of the word *practical* to a book on therapeutics which devotes three and a half pages to Typhoid Fever, and five to Tuberculosis, and eleven pages to Epilepsy, after saying, to begin with, that it is the "most disheartening condition as to treatment that the physician has to deal with."

A few typographical errors are to be found. The one on page 338, recommending one-fifth of a grain of strychnine three times a day, might be disastrous.

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## TO CONTRIBUTORS.

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## Original Communications.

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### FRACTURE OF THE CARTILAGINOUS PORTION OF THE NASAL SEPTUM FOLLOWED BY ACUTE TRAUMATIC PERICHONDritis.

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By CHARLES DUNBAR ROY, A. B., M. D.,

Assistant to the Chair of Eye, Ear and Throat, Southern Medical College,  
Atlanta, Ga.

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The history of the following case which came under the care of Dr. A. G. Hobbs and myself was one to me of much interest, and through the kind permission of Dr. H. I am enabled to give to the readers of this journal a report of the same. Many injuries of the nose and its accessory cavities have come under my observation, but none of them ever presented the especial features of this one.

M. J., student, age 19, presented himself at the office for con-



sultation Monday, May 18th. From him the following history was elicited. On the Friday previous, while engaged in a game of base ball, the ball accidentally slipped through his hands and struck him on the tip end of his nose. The inconvenience occasioned at the time was slight, there being but little pain and scarcely any bleeding. He retired that night feeling comfortable and enjoyed a good night's rest. On the following morning he found his nose much swollen and considerable interference with nasal respiration. On Saturday and Sunday the conditions remained the same. Hot water was used externally, in conjunction with the topical application of borax and vaseline. On Monday morning he presented himself at the office.

*Examination.*—By inspection the cartilaginous portion of the nose externally showed considerable swelling. By tilting up the anterior extremity and with the aid of reflected light, the nasal cavities could be brought into view, showing complete occlusion of the canals. The occlusion was formed by protrusions from each side of the cartilaginous portion of the septum. The patient could scarcely obtain a passage for air by the most strenuous exertion. The septal cartilage gave the appearance of having been pulpified by the blow.

By palpation with the tips of my little fingers introduced into the canals, the condition of the septum was still further ascertained. The cartilage was easily movable to first one side and then the other, with an occasional exception. The anterior half would move without seeming disturbance of the posterior portion, though the swelling and œdema were so great as to make the manipulation somewhat difficult. By means of a probe, pushing the septum to one side, and the reflected light, the œdema and inflammatory state could be seen to subside at the junction of the cartilaginous and osseous portion of the septum. It looked as if the cartilage had been mashed down from above and spread out laterally, which, however, was not the case, since the fracture was vertical and occasioned evidently by the blow striking anteriorly. Naturally there was considerable tenderness. Some little bleeding had occurred from the left side. By palpating the protruding masses the evidence of some fluid could be distin-

guished, but by no means marked. Considerable bloody serum would exude when the septum was pushed to one side and a forcible expiration was made by the patient. The nasal bones were intact. The turbinates were in no wise enlarged or œdematous.

The treatment consisted in thoroughly cocaïzing the parts in order to allow a more perfect examination, and at the same time to see if there would be any appreciable contraction of the tissues. Two firm plugs of absorbent cotton, saturated with a bichloride solution, were introduced anteriorly for the purpose of their exerting some pressure upon the sides of the septum. The patient was ordered a solution of aristol in liq. albolene, to be introduced anteriorly with a glass dropper and allowed to permeate the tissues.

May 19th. Condition about same. The presence of fluid was seemingly so slight that the plugs were again introduced in hopes of keeping the septum vertical and at the same time aiding absorption. Fortunately, with the fracture there was no decided septal deviation.

May 20th. Slight diminution in the size. The plugs were used during the day and removed in the afternoon.

May 21st. Left side looking much better where there was a freer escape of serum. Right side tender. Plugs used during the day.

May 22d. Swelling much less. Breathes slightly through both sides. Plugs soaked in vaseline were renewed. Vaseline was found to act much nicer, not producing that sobby appearance of a watery solution.

May 23d. Plugs discontinued. The passages are a little freer.

May 26th. About the same. Both sides sprayed with oil of eucalyptol in vaseline. The protuberances were painted with a solution of nitrate of silver (5 grs. to 3).

May 27th. Very slight change. Plugs did not meet the desired result. Scarification was used on the right side.

May 28th. Mucous membrane on the left side of the septum thoroughly incised, followed by the evacuation of about two or

three drachms of sero-pus. This was followed with a collapse of the membranes on both sides of the septum, and increased nasal respiration. Both sides thoroughly sprayed.

May 29th. Right side incised, followed with blood and serum. Aristol in liq. albolene (10 grs. to 3) used throughout the treatment.

June 3d. Parts looking much better. Left side again incised. Septum painted on both sides with silver (10 grs. to 3).

June 9th. Application of silver again made. Breathing much freer.

June 17th. Right side nearly normal. No septal deviation Union restored. Left side painted with silver (20 grs. to 3).

June 23d. Both sides looking normal. Slight ridge on the left side following the line of fracture.

August 20th. Patient appeared at office on account of an interference with breathing on the left side.

Examination showed some thickening of the cartilage throughout its whole extent. The ridge running vertically at the line of fracture in the left fossa affords some resistance to the entrance of air. Secretion is prone to gather at that point. Inferior turbinate somewhat hypertrophied.

Had the case been left untreated, trusting to the *vis medicatrix naturæ*, the result would probably have been far different. That the case in time would have recovered and fairly good breathing obtained, at least on one side, there is no doubt, but the probabilities are that there would have been left a large enchondroma occluding the canal on that side, or a very severe septum deviation bringing the same results. Some very distinguished rhinologists believe that blows upon the nose are more often the etiological factors in producing septum deviations and spurs than any other cause, and I must confess that in all severe cases of this pathological condition which have come under my observation, I have been able to elicit from the patient the history of a blow during some period of his previous life. The term "pathological condition" has been used, a term which requires still further explanatory remarks, for I believe with many other observers that some deviation of the septum is the normal con-

dition, and only reaches a pathological state when it interferes with the proper physiological functions of the nasal apparatus. Thus in the case herein described a few sprays and cautery of the turbinate were deemed sufficient without further radical measures. The case presented is an interesting one, as well as one of much uniqueness. I have been unable to find any similar or quasi-similar case mentioned in the literature at my disposal. Bosworth, in his late extensive work on the nose and throat, has nothing upon the subject. Traumatism of the nose is by no means an infrequent accident. From its decidedly protruding character and prominence in the make-up of the facial anatomy, one would suppose that it would most often be the objective point for the reception of blows directed and those unintentional. Such is probably the case, although no writer of whom I am cognizant has compiled statistics of the frequency of *nasalities* as compared with those of other portions of the face. A blow upon the nose is very distressing to the recipient, both *post hoc* and *propter hoc*, bringing tears alike to the happy as well as the morose. The physiology of the fifth cranial nerve, its relations and reflex actions, is an interesting study, but my object is no extended essay, but simply to add a few remarks to the case already presented. Any severe blow upon the nasal extremity is likely to cause some œdema and some interference with nasal breathing. This occurs whether the obstruction be confined to the outer wall of these cavities or to the septum itself. All the tissues of that portion known to the laity as the nose, i. e., the soft portion which gives character to the nasal expression, is apt to be involved. The mucous membrane covering the turbinate bones is of the character known as erectile tissue, that is, tissue which becomes enlarged by the engorgement of its capillary spaces. While this portion of the nose is not prominent enough for the direct reception of a blow, yet the transition of its mucous membrane with the skin is so intimate and the blood vessels of both so communicable that both are usually simultaneously involved. Any one who has ever given thought and study to the subject knows how prone to engorgement is the mucous membrane in this region, so that whenever the slightest opportunity offers itself for the fulfillment of

this condition, it is seized with avidity. And hence arise our nasal stenosis in acute rhinitis. In the present case, however, the enlargement was confined entirely to the cartilaginous portion of the septum with no involvement of the external lateral walls of the cavity nor of the mucous membrane covering the bony portion of the septum. The blow in striking the septum anteriorly caused a bending and fracture vertically, of the cartilage since its attachment to the bony portion posteriorly prevented the further transmission of the blow. The cartilage thus gave way at its weakest point, which in this case, as would naturally be supposed, was a point midway in the horizontal diameter. With this fracture came a rupture of the adjacent arterioles and mucous membrane, which thus caused the effusion of blood and subsequent bulging of the membrane. The protrusions from each side of the septum were of equal dimensions and communicable, as was demonstrated after the puncture. In the process of repair a ridge was left, running vertically, following the line of fracture, of a decided thickening throughout the whole cartilaginous portion of the septum, as the examination showed on August 20th. At that time the stenosis occasioned by the ridge was slight, so slight as to need no operative interference.

In the treatment of all such cases a palliative, rather than a radical, measure is the course to be pursued. Should the fracture be attended with decided inclination to one side or the other, pressure in some form should be made, in order that the final result may not be a deviated septum. The wearing of plugs of any description is exceedingly annoying, as any who has ever worn them can testify, and in case of fracture of the cartilaginous portion of the septum, they do not perfectly meet the end for which they were intended. That they do some good cannot be denied. One must remember that the nasal septum, anterior to the superior maxilla bones, has but a small triangular portion of cartilage to fill the space between the vomer and perpendicular plate of the ethmoid, as can readily be seen by examining a skull. All the front portion of the nose consists of soft tissues capable of distention, and the inefficacy of plugs to make pressure upon the septum was forcibly illustrated to me by the case in question, the

whole blunt of the pressure being in the distention of the soft tissues laterally (externally). Should the mucous membrane of the septum be much swollen, the nature of the enlargement may be diagnosed by the introduction of the tips of the little fingers into each nasal cavity and the portion palpated. Should fluid be detected, the part should be thoroughly cocainized and a free incision be made down to the cartilage. This procedure should be done on only one side at a time, since the pain and soreness subsequent is a condition which sometimes follows. A warmed spray of eucalyptol in vaseline must be used throughout the course of treatment. On the next day the other side may be punctured if necessary, and if deviation exists the septum compressed with Bosworth's rhinoplastos. This latter plan is much more effective than plugs, and should be done every morning in order to allow the healing process to leave the septum in its normal position. Occasionally the deviation is so great that a septal clamp has to be worn for a couple of days. As soon as all serum or sero-pus, as in the case presented, has been permanently evacuated, the mucous membrane and hyperplastic state of the tissues should be contracted by the application of some astringent, preferably nitrate of silver (20 grs. to 3). The resultant condition of the nasal cavities after this plan of treatment will usually prove satisfactory. Later should secretions gather at any point and the mucous membrane look roughened, vaseline sprays applied night and morning will usually restore the parts to a normal condition.

14½ Whitehall St.

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## SOURCES OF ANIMAL HEAT.

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BY A. D. BARR, M. D., CALAMINE, ARK.

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The text-books, generally, treat animal heat as mainly due to chemical action, and that this action consists in the oxidation of the food consumed.

Also, that the amount of animal heat can be tolerably accurately calculated by ascertaining how much heat the food is capable of liberating when completely oxidized, but as the food is not completely oxidized in the body, the amount of heat that can be generated, which is contained in the excreta, must be deducted.

In an address delivered before the Ninth International Medical Congress, Prof. Austin Flint said:

"In a series of experiments made upon my own person, for twenty-four hours, under a liberal diet, I calculated the heat value of the food ingested as equal to 14, 979.15 heat units.

"At that time (1878), I weighed 186½ pounds, and according to my estimate I produced 17,880 heat units in twenty-four hours. There was no difference in the body weight at the beginning and at the end of the observation. These observations show that nearly one-sixth of the heat estimated as actually produced by the body, was not accounted for by the heat value of the food.

"There can be little question with regard to the accuracy of the accepted method for estimating the heat value of articles of food, and it follows logically that there must either be a grave error in the estimation of the heat produced by the body, or there are certain processes going on within the body not taken into account by physiologists, which involve a considerable production of animal heat. It is to be remembered, also, that I made no allowance for the conversion of a certain portion of the heat produced in the body into force expended in circulation, respiration, locomotion," etc.

As it is a well established fact that heat is generated in the body by the process of oxidation, and as the object of this article is to call attention to what I believe to be the sources of animal heat, I pass over that part which has been thoroughly established. As animal heat differs in no way from any other heat, and as any force that will produce heat without the body will also produce it within, it becomes necessary to examine the body and see if there are any forces within it that can be converted into heat, and if so it is to them we are to look for the explanation of the excess of heat produced within the body

above that which is contained in the food, which was pointed out by Prof. Flint.

As the friction of the blood against the walls of the blood vessels and that of the muscles has been credited with the production of a certain portion of animal heat, I will pass over these forces also, without further notice.

#### HEAT DUE TO PRESSURE.

If a body be compressed its temperature rises according to the diminution of its volume. In the body the entire force of the heart's action is converted into heat, and this force has been variously estimated at from 124 to 200 foot tons daily. In the case of the heart the force it contracts with drives the blood as far as the capillaries, by which time its force has been mostly expended in overcoming the pressure under which it labors, and when force is lost heat is generated, or rather the force is converted into heat. The effect of a division of the sympathetic nerve in the neck is to relax the arterioles of the side of the head corresponding to the lesion; those of the ear, for example, become more conspicuous and its temperature is considerably increased, and if the head is protected from external cold the venous blood, after division of the sympathetic, will be found to exceed in temperature that of the arterial.

Thus I believe, demonstrating the position I have taken, that the force of the heart's action is entirely converted into heat by the time the blood reaches the capillaries, and, is there partially reconverted into force, which serves to maintain the circulation. In the case of the division of the sympathetic nerve the arterioles become dilated as a self-evident consequence, as much force is not required to maintain the circulation, and the overplus of the force of the heart that was converted into heat is not reconverted into force, the consequence of which is, the venous blood returned from the region of the lesion is of higher temperature than that of the arterial blood which supplies it.

#### HEAT DUE TO ABSORPTION.

Motacular action, for example absorption, is usually followed



by a rise of temperature. Pouillet found when a liquid is poured on a pulverized solid heat is generated, and that the amount of heat thus produced varies according to the nature of the substance. With organic substances, as the metals, the increase is four-tenths of a degree, but with organic substances, as for example, starch or flour, the increase varies from one to ten degrees. The absorption of gases produces the same phenomenon. If the absorption of a fluid outside of the body is capable of generating heat, it should be conceded the same property within it, and if it be admitted that the absorption of a fluid is capable of liberating heat within the animal economy, and if the degree of heat so generated be comparable to that generated by the absorption of a fluid by such bodies as starch, flour, roots, dried membranes, etc., we have a source that must be credited with no inconsiderable place in the production of animal heat.

The constant absorption of gases that are constantly taking place in the animal body is of course likewise followed by the generation of heat. It is, I believe, only by the sources of heat here considered that the difference pointed out by Prof. Flint in the heat value of the food and the amount of heat actually generated by the animal body can be accounted for.

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## OVARIOTOMY DURING PREGNANCY.\*

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By CHRISTIAN FENGER, M. D., CHICAGO, ILL.

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It would seem strange to bring this important subject before the Society with only one case as an illustration. I do not pretend to bring forward anything new or anything of my own, in this connection, but merely desire to present to the Society the thoughts and reflections that I experienced after looking over the literature on the subject. This has been the more interesting to me because of the radical changes in the views as to the

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\*Read before the Chicago Gynecological Society, May 22d, 1891.

choice of treatment of this condition which have taken place within the last ten years.

CASE.—Mrs. G. E., 30 years of age, primipara. Health always good up to the time of this sickness; she had never been treated for any uterine disease. First menstruated at 14; until the nineteenth year she was occasionally troubled with frequent and profuse menstruation. From the nineteenth to the twentieth year the menstrual flow was regular, but scanty. After the twentieth year it again became normal, and continued so until the time of the last menstruation, May 21st, 1890.

She was married in 1886, at the age of 25, and was well from that time until pregnancy, with the exception of some attacks of pain in the lower part of the abdomen, radiating from the lumbar to the inguinal regions. The pain would come on suddenly, had no connection with menstruation, would last from fifteen minutes to half an hour, and would be followed for several days by tenderness over the lower part of the abdomen. She generally felt chilly during these attacks, but had neither fever nor vomiting. She has had five attacks in all; the first one five years ago, the second a few days later, the third a month later, the fourth a year after the third, and the last attack during January, 1890. Dr. Hartman, her family physician, to whom I am indebted for the information as to her previous history, considered these attacks to be ovarian colic. She consulted Dr. Hartman on July 26th, 1890, when she complained of failing health, general weakness, loss of appetite and flesh, having lost sixteen pounds within five weeks. She further complained of pain and considerable tenderness in the left inguinal region, and had not menstruated since May 21st.

On bimanual examination the uterus was found slightly enlarged, mobile, and pushed over to the left side by a tumor which partially filled the pelvis minor. It did not appear to be firmly adherent to the uterus. An upper portion of the tumor projected above the brim of the pelvis in the right lower part of the hypogastric region. It appeared movable. The surface, although smooth, was not uniform in appearance, inasmuch as the portion in the large pelvis appeared to be solid, while the

portion felt through the vagina was elastic and appeared to fluctuate. Dr. Hartman made a diagnosis of dermoid cyst, and this diagnosis was confirmed by the examination October 24th, 1890. The gravid uterus was now found projecting in the hypogastric region, the size of the uterus of the fourth month. Auscultation revealed uterine bruit, but no fetal heart sounds. The tumor had also increased in size, and on examination was found to almost fill the pelvis minor. The wall was in some parts hard and nodular. The upper part could now be only indistinctly felt, as it was covered by the gravid uterus. The patient had not felt any fetal movements, but had had frequent shooting pains in the mammæ, which as yet were not enlarged or changed in appearance. Her general health had improved during the summer.

October 24th I examined the patient in consultation with Drs. Hartman and Lee, and confirmed the diagnosis of dermoid cyst in the small pelvis on the right side of the uterus, and pregnancy of the fourth month. The ovarian tumor was immovably fixed in the small pelvis, and the vaginal portion of the uterus could now be felt high up to the left side and apparently movable against the tumor.

In consultation held as to what course to pursue, it was thought likely that this ovarian cyst, which almost filled and was incarcerated in the small pelvis, might be a dangerous complication to the delivery, or might rupture later on in the course of pregnancy. After considering the choice between the induction of premature labor and subsequent ovariectomy on the one hand, and ovariectomy during pregnancy on the other hand, the latter was decided upon, and the patient taken to the Emergency Hospital and prepared for laparotomy in the usual manner.

October 30th, in the presence of the doctors from the Polyclinic and some of my students from the college, and assisted by Drs. Bernauer, Lee, and Hartman, the anæsthetic being administered by Dr. Rosa Engert, the operation was performed as follows :

An incision was made in the median line from the symphysis pubis to the umbilicus, the pyramidal muscles transversely divided, and the parietal peritoneum sutured to the skin. The gravid uterus presented through the abdominal wound, and the

tumor could be felt deep down and behind the uterus, but was inaccessible until the incision had been prolonged above the umbilicus to midway between the latter and the ensiform cartilage.

On introduction of the left hand into the abdominal cavity a cyst could now be felt of the size of a small child's head, the lower part of the tumor filling the small pelvis to the right of and behind the uterus, an upper portion projecting up into the pelvis major. The cyst was so firmly incarcerated in the small pelvis that it could not be removed so as to bring it up into the wound. As I expected to find a dermoid cyst, I did not want to empty its contents in order to facilitate its removal. Therefore I enlarged the abdominal incision still a little further upward, and everted the gravid uterus out through the wound. The uterus was wrapped in warm aseptic cloths soaked in sterilized water, and was held on the outside of the abdominal cavity and to its left side by Dr. Bernauer.

I now introduced the left hand down into the small pelvis behind the cyst, and lifted it up and out through the abdominal wound. It was found to have a smooth surface and to be non-adherent. After having packed the abdominal cavity around the pedicle, the cyst was removed entire. It was somewhat difficult to ligate the broad ligament, as the pedicle was short, especially in the upper part of the broad ligament, which was unfolded and filled by the gravid uterus. The pedicle was trans-fixed and then dropped, without, as I usually do, dividing it on the clamp by Paquelin's cautery, because the pedicle was too short to permit the application of the clamp. After dropping the pedicle the cloths around the uterus were removed, and, after turning the patient on the side, a pitcher of sterilized water was poured over the uterus, which, after the removal of the large flat sponges, was replaced. It was somewhat difficult to push the uterus back through the wound, the borders of which had to be tightly drawn during its replacement. Several small, subserous ecchymoses had formed on the surface of the uterus during its stay outside. Small sponges on sponge holders, pushed down behind the uterus, showed the abdominal cavity to be free from

blood and serous fluid. The abdominal wound was then united with alternate deep and superficial sutures ; no drainage.

At the end of the operation, which lasted an hour and a quarter, the patient was in natural condition ; pulse 90, strong ; no symptoms of collapse.

The second evening after the operation temperature rose to 100.8°, pulse to 96. During the rest of the first week after the operation the morning temperature did not reach 99°, the evening temperature being about 99°. From the beginning of the third week the temperature remained normal.

During the first two weeks the only important symptom was occasional severe paroxysmal pain, simulating uterine contractions ; it could, however, be controlled by repeated hypodermic injections of a quarter of a grain of morphine. This pain made me fear impending abortion, but it gradually decreased, and entirely ceased at the beginning of the third week.

On the fifth day the dressings were changed and the wound found to be perfectly dry and aseptic. The patient was sitting up at the end of the third week.

The subsequent course of the pregnancy was entirely normal, and on February 19th, 1891, the patient fell in labor, which lasted fifteen hours, the child being delivered by forceps. The child was fully developed, at full term, and weighed six pounds. The convalescence after delivery was not attended by fever, but was somewhat tedious. The patient had only a small quantity of milk, and so after three weeks artificial alimentation was tried but proved injurious to the child. A wet-nurse was then procured, after which the child recovered and is now doing well. The mother regained her strength slowly but fully ; she suffered for a time, however, from looseness of the bowels and indigestion.

In the cicatrix at the line of incision and at the point of insertion of the sutures a remarkable degree of pigmentation took place. Dr. Hartman stated that the entire cicatrix became deeply pigmented—in fact, almost black. The patient herself declared that this pigmentation did not begin to appear until after labor (?) It reached the maximum degree of color after delivery,

from which time it began to fade, and at the end of nine weeks had almost disappeared, leaving only a light brown cicatrix.

The tumor was a dermoid cyst with the usual characteristics of such tumors. At the time of removal it was about the size of a child's head at term ; it now appears considerably smaller on account of the shrinking of the cyst wall in the alcohol. The outer surface is smooth, free from adhesions, but uneven ; in some places thin, in others consisting of hard, nodular tumors from a quarter of an inch to an inch in diameter. One portion of it forms a solid mass the size of a small hen's egg, which consists of whitish solid tissue and includes a cyst, the size of a walnut, densely packed with brownish hair. On the inner wall of the larger cyst, which is smooth in its upper portion, may be seen, down near the large tumor, a number of smaller cysts from the size of a pea to that of a hazelnut. In some places the cyst wall is quite thin and transparent, indicating the liability of rupture upon manipulation or by pressure during delivery.

*Remarks.*—Ovarian tumors, which are at all times a source of danger, are still more so when complicating pregnancy, as the two conditions, when in combination, mutually influence each other, to the detriment of both mother and child. The ovarian tumor is subject to acceleration of growth, to more rapid development, during pregnancy. The gravid uterus is liable to cause torsion of the pedicle by changing the form and position of the latter, or by circulatory disturbances in the pedicle, resulting in gangrene or perforation of the cyst. When situated in the pelvis minor, an ovarian tumor is especially liable to become an obstacle to the delivery of the child, and to cause difficult and consequently dangerous labor, which may result fatally to both mother and child.

In discussing the measures for the prevention of these dangers, we will first consider the fate of the mother and child when pregnancy is left to run its course. The dangers to the mother, as gathered from the statistics, are the following : Litzmann has collected fifty-four cases, with twenty-four maternal deaths ; Jetter, two hundred and fifteen deliveries in one hundred and sixty-five mothers, with sixty-four deaths ; Playfair,

fifty-seven deliveries, with twenty-three deaths ; Braxton Hicks, six deliveries, with no deaths ; Rogers, five deliveries, with no deaths ; Spencer Wells, eleven deliveries, with one death ; Fritsch, four deliveries, with one death. In all three hundred and fifty-five deliveries are reported, with one hundred and thirteen maternal deaths, or a maternal mortality of about thirty-two per cent.

The mortality to the children from either abortion or premature labor, according to Engstrom, is much greater. In a series of two hundred and sixteen cases a mortality is reported of forty-eight per cent.

The proliferating cystoma is the form of cyst most commonly observed. They are frequently located outside of the small pelvis, and are often overlooked during pregnancy. They rapidly increase in size, and may cause over-distention of the abdomen and severe pressure symptoms from the organs of the abdomen and thorax, necessitating speedy relief. In such cases the treatment by puncture comes in question. As these cysts are located outside of the small pelvis, they are not liable to prove a serious impediment to delivery. Thus it would seem that small dermoid cysts located in the pelvis minor constitute the gravest complication of ovarian tumors with pregnancy.

Dermoid cysts are common. Jetter found thirty-seven dermoid cysts in one hundred and sixty-five cases. They are often small and thus remain in the pelvis, are easily diagnosed by vaginal examination, and therefore, as Olshausen states, are seldom overlooked. These are the tumors which most frequently prove a serious difficulty at the time of delivery, when immovably incarcerated in the pelvis minor.

Puncture of the dermoid cyst is dangerous, as its contents are more poisonous than that of most of the other ovarian tumors ; but puncture becomes unavoidable at the time of delivery when the cyst cannot be pushed out of the way up into the abdominal cavity. The usual location of dermoid cysts in the pelvis minor makes liable the occurrence of spontaneous rupture during delivery, with consequent septic peritonitis resulting partially from

infection from the contents of the cyst, and partially from mixed infection through the puerperal wounds.

*Treatment.*—While, outside of pregnancy, prompt extirpation of an ovarian tumor is always indicated, widely different measures have been advocated for the treatment of ovarian tumor when complicated with pregnancy.

1. Induction of abortion and premature labor has been recommended by Barnes, but in most cases this sacrifices the child and is not without danger to the mother. In five cases cited by Olshausen two mothers died. As ovariectomy necessarily must follow, this method of treatment exposes the mother to the dangers of two serious operations.

2. Puncture of the cyst to relieve the symptoms and so permit natural labor to be undisturbed. This procedure, like the preceding one, is of course only temporary and resorted to with a view of awaiting the earliest opportunity for ovariectomy. Puncture of the ovarian tumor may relieve the dyspnoea and prevent abortion. It is not more dangerous in pregnancy than under ordinary circumstances, but the puncture of ovarian tumors in general is attended by a mortality of nineteen per cent. Cohn states that one out of every six ovarian cysts is malignant; therefore puncture might cause rapid diffusion of the malignant tumor in the peritoneal cavity—malignant peritonitis. The more rapid growth of ovarian tumors during pregnancy is apt to cause refilling of the cyst after puncture, and thus necessitate repeated punctures, which, of course, will increase the danger to the mother. Cohnstein states that of six mothers in whom puncture had to be repeated three or more times during pregnancy, five, or eighty-three per cent., died within a short time after delivery from exhaustion. Puncture does not predispose to the interruption of pregnancy in more than eighteen per cent. of the cases.

The difficulty in differential diagnosis between an ovarian tumor and the gravid uterus is apt to lead to puncture of the latter. Olshausen states that in seven cases the uterus was mistaken for an ovarian tumor and punctured. The operator then



made a Cæsarean section, sutured the uterus, and closed up the abdomen. This was done in five cases with success; in two cases the puncture terminated fatally.

3. During the last few years a third method of treatment of ovarian tumors during pregnancy has come into the field, namely, ovariectomy during pregnancy. This operation is comparatively new, as in 1877, according to Olshausen, only fourteen cases were on record. In the next year over forty cases were on record, and now this method of treatment bids fair to become a regularly established procedure. Although ovariectomy in the pregnant woman was at first performed with a good deal of apprehension, it has been seen from the very beginning, that the dangers were highly overrated, and that the mortality for mother and child has been decreased by this operation far beyond our expectations. In 1886 Olshausen collected eighty-two cases with only eight deaths, but he points out that individual operators had a much lower mortality, as out of thirty-six cases operated upon by Lawson Tait, Spencer Wells, and Schroeder, only one mother died.

Engström, in 1890, reported a series of forty-eight cases with only two maternal deaths, or a mortality of four and two-tenths per cent, as follows: Schroeder, twelve cases, no deaths; Lawson Tait, eleven cases, one death; Spencer Wells, ten cases, one death; Olshausen, eight cases, no deaths; and Engström, seven cases with no deaths.

I consider the mortality of the operation to-day to be below five per cent. therefore, ovariectomy during pregnancy is not any more dangerous than this operation in the non-pregnant condition.

The fate of the child is influenced by this operation to a like favorable degree. According to Olshausen, abortion follows ovariectomy in only twenty per cent. of the cases; hence eighty per cent. of the children were born at full term. When we compare this with the mortality to the children of forty-eight per cent. with non-interference, we see that by ovariectomy twenty-eight per cent. of the children are saved.

It is generally thought, and probably it is true, that the earlier in pregnancy an ovariectomy is performed the more favorable is

the result. Wilson states that ovariectomy becomes less favorable after the fifth month, because, as Schroeder has pointed out, the operation becomes more difficult by shortening of the pedicle, on account of the unfolding and filling in of the broad ligament to which the tumor belongs by the gravid uterus. Late in pregnancy the size of the uterus naturally makes the operation difficult by decreasing the available operating space in the abdominal cavity. This sometimes necessitates the inconvenient lateral operation to gain access to the ovarian tumor. The vascularity of the tumor and pedicle late in pregnancy always increases the difficulty of the operation. But in such cases the facts have proven a surprise to our expectations. Olshausen reports twenty-one cases operated upon after the fourth month, with only two deaths. Pippingsköld reports an operation made after the commencement of labor which resulted successfully. Stratz reports fourteen operations performed by Schroeder, with no maternal deaths and with twelve living children, and formulates the answer to the question whether ovariectomy should always be performed during pregnancy, that it should be done as soon as the diagnosis is made, because:

1. Ovariectomy is inevitable, and its prognosis is not aggravated by the presence of pregnancy.
2. Delivery in childbed without the tumor has a much better prognosis than when the tumor exists.
3. One out of six tumors is malignant, contraindicating puncture.
4. Prognosis for children is much better.

He formulates the following conclusion: "The complication of ovarian tumor with pregnancy indicates ovariectomy."

In the discussion which followed the reading of this paper Weit and Löhlein protested against laying down absolute rules, and suggested that it might be well to individualize. Schroeder, however, fully supported Stratz's recommendation always to operate.

*Final Remarks.*—Small tumors in the pelvis minor are especially dangerous to the child and mother, as has been well illustrated in a case published by Lomer, in which a secundipara, 21

years of age, had an ovarian tumor in the small pelvis the size of a child's head; after rupture of the bag of waters extraction by the foot was tried in vain. Prolapse of the umbilical cord and death of the child resulted, followed next day by version in narcosis, during which the child's head was torn off, and the patient died from collapse in three hours.

In another case, published by Nölting, a small ovarian tumor in the pelvis made delivery difficult in the following way: Forceps were first applied in vain; puncture of the tumor evacuated only a small amount of blood. The child died, and was only extracted after perforation, and still with difficulty, as the tumor came down so far in Douglas' fossa that prolapses of the rectum took place. The patient died after four days of peritonitis. The autopsy showed a double twist of the pedicle, with rupture of the cyst.

Instances of this kind on the one hand, and the low mortality of ovariectomy during pregnancy on the other, would tend to lead to the conclusion that in small ovarian tumors located in the small pelvis and diagnosed during pregnancy immediate ovariectomy is the safest procedure.

## BIBLIOGRAPHY.

- Olshausen: Die Krankheiten der Ovarien, p. 129.  
 Stratz: Ueber der complication der Tumoren und Gravidität, Zeitschr. f. Geburt. und Gynäkologie, Band xii., Heft. 2, p. 262.  
 Engström: Annales de Gynécologie, October and November, 1890.  
 Cohnstein: Volkmann's Sammlung klinische Vorträge, No. 59.  
 Lomer: Centralblatt für Gynäkologie, No. 42, 1890.  
 Nölting: Ibid.

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## TWO CASES OF FIBROID TUMOR OF THE UTERUS SUCCESSFULLY TREATED BY WEAK CURRENTS OF GALVANISM.\*

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By J. A. LYONS, M. D.

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The following cases, which I have observed while assisting Dr. T. J. Watkins at his clinic in the Post-Graduate Medical

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\* Read before the Gynecological Society of Chicago, June, 1891.

School of this city, may be of interest, as they suffered from profuse and almost continuous metrorrhagia, and as their treatment consisted only in the use of weak currents of galvanism.

CASE I.—Mrs. C., 22 years of age, married four and one-half years; the mother of one child  $3\frac{1}{2}$  years old. She miscarried six months ago, at about the fourth month of gestation, at which time she suffered from puerperal septicemia and entered St. Luke's Hospital for treatment. During this time she flowed almost incessantly, and frequently hemorrhage was profuse. She continued to lose blood in this manner until January 30th of this year, when she applied for treatment at the dispensary of the Post-Graduate Medical School. Her health previous to the miscarriage was good, although her physique is slight and her temperament nervous. She came to the clinic for relief of metrorrhagia and of pain in the left inguinal region. She was excessively anemic and greatly debilitated.

Physical examination revealed a symmetrical enlargement of the uterus about the size of four months' gestation, which was diagnosed as an interstitial fibroid tumor. The depth of the uterus could not be ascertained, as a probe could not be passed beyond the os internum.

Galvanism was given as follows: 1. Apostoli's clay electrode was placed on the abdomen over the region of the tumor, and to this was fastened the negative pole of the battery. 2. The Apostoli intra-uterine electrode was introduced, but could only be passed to the internal os, and to this was attached the other pole of the battery. The electricity was now gradually administered until forty milliamperes were given, when the patient experienced some pain. This current was continued for three minutes.

February 3d—that is, four days later—the above treatment was repeated.

February 6th. Patient has had no hemorrhage since last treatment until this morning. The positive pole is again introduced into the uterus and the current increased to fifty milliamperes.

February 10th. No hemorrhage since last treatment. The electrode is easily passed for the first time into the cavity of the

uterus for four and one-half inches, and is made the negative pole of the battery. This treatment was repeated on February 13th, 17th and 20th.

February 27th. She has just completed a normal menstrual period. Fifty-five milliamperes were given. The tumor is reduced to about three-fourths its original size. Her general condition is much improved.

March 20th. The galvanism has been given twice each week, as above described, and now the uterus is normal in size and position; the patient feels perfectly well and is discharged cured. Although the current given was weak and continued for only three minutes, yet at times she suffered so severely after the administration of the galvanism that she was forced to remain quiet in the hospital for two or three hours before returning to her home. About one month later, at our request, she returned to the dispensary feeling perfectly well, and examination again showed the uterus to be normal in size and position. In this case it is interesting to note that the metrorrhagia was cured while the electrode did not enter the uterine cavity.

CASE II.—Mrs. C. Piper, living on North Robey street, American, aged 36 years and married eighteen years, has one child 17 years of age. She has had two miscarriages fifteen and thirteen years ago. For two years she has suffered from bearing-down pelvic pains and with severe pains in both inguinal regions and in back. Menstruation has been profuse for nearly two years, and has gradually become more painful, until now it is very severe, and for four months she has flowed almost continuously. The blood at times has been bright red and at other times dark and clotted.

Physical examination revealed a fibroid tumor of the uterus about the size of six months' pregnancy, which protrudes to the right and posterior. Galvanism was given practically as in Case I. The patient attended the clinic faithfully twice each week, although the treatment gave her but little if any relief for one month. Then the electrode was passed with difficulty into the cavity of the uterus. This could only be accomplished by placing the patient in the left lateral position, by exposing the cervix by

means of a Sims' speculum, and straightening the uterus by traction on the cervix with a tenaculum. The canal was found to be very tortuous and six and one-half inches in depth. After this the resistance to the electrical current became much diminished, her hemorrhages abated, and her general condition rapidly improved. The strength of the current varied from thirty to seventy milliampères.

May 19—that is, forty-five days after the treatment was commenced, and fifteen days after the electrode was passed into the cavity of the uterus—the tumor is reduced about one-sixth in size and the patient is much improved.

June 9th. Patient is quite active and is now doing much of her own housework, while formerly she could attend to none of these household duties.

June 19th. Tumor is now about three-fourths its original size. Patient menstruates regularly, but not excessively and without suffering much pain. Her strength is practically restored and she now suffers but little from pelvic pain.

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## ONE HUNDRED CONSECUTIVE CASES OF SKIN DISEASE.\*

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### IX.

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By M. B. HUTCHINS, M. D.,

Lecturer on Diseases of the Skin, Atlanta Medical College, Atlanta, Ga.

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The case diagnosed as *xeroderma pigmentosum* was seen over a year ago, and this diagnosis was provisional. It is of sufficient interest to deserve separate publication, and I hope to be able to complete the history in such a manner as to make it worthy of being laid before my readers at some future day.

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\*ERRATUM.—In article VIII. "*Carcinoma Cuticulare*" should have been printed, *Carcinoma Lenticulare*.

## URTICARIA.

*Two Cases.*—First, a young lady of twenty-one. Began on arms six days before consultation. When seen, almost the entire skin surface was involved, regardless of localization. Lesions were “wheals” and papules, former average finger nail in size; latter pea-sized; the larger lesions of pinkish color, resembling mosquito bites. First symptom was itching. Rubbing the skin for relief of itching brought out the lesions. Scratching had caused the formation of a minute blood crust on top of papules, making these lesions, at a little distance, resemble those of scabies, but the hands were not affected.

Headache since beginning of eruption. Tongue slightly furred, patient of constipated habit. Appetite good.

*Treatment.*—Ordered to take a free dose of Epsom salts at bedtime. For future constipation the “cascara and nux” mixture—which has already been mentioned in these articles. Locally the following was ordered:

R. Zinc ox., ʒvi.

Camphor., ʒiii.

Aquæ calcis., ʒiii.

Aquæ, ad. ʒvi.

M. Sig.—Shake, and apply frequently.

This patient was not seen again. She got married three days later.

Second case, young man of 22. Whole cutaneous surface irritable and “wheals” easily caused to appear. On right wrist bright redness and two “wheals” the size of a silver half dollar. Redness of skin of lower third of thighs and about knees. Here and also on the legs were several red wheals from the diameter of a hazelnut to that of a half dollar, redness momentarily removable by pressure. Attack was preceded by irritability of skin and had been present for two days. A somewhat similar attack five weeks previous to present. Swelling of the face and upper lip was present, when patient first got up in the morning, in both attacks. Individual lesions of the disease remain only a few hours, but others continue to form. Patient thinks he had a similar disease in infancy. Severe attack of rheumatism five

years preceding consultation, and occasional "touches" since. (Since this record was completed the gentleman has had another severe attack of rheumatism, lasting several weeks. Urticaria is not infrequently found in rheumatic subjects.)

*Treatment.*—Saline cathartic ordered. Spray face, if swells, with ether, and if upper lip again becomes swollen immerse it in hot water.

℞. Calamin. prep.,  
Zn. ox., aa ℥ii.  
Ether. sulph., ℥ii.  
Hg. bichlor., gr. v.  
Aquæ, ad. ℥vi.

M. Sig.—Shake and apply as often as possible.

Attack subsided within twelve hours. Cathartic was not taken and patient had a slight outbreak on posterior of thighs. Ordered to "open bowels freely" and continue treatment. Soon recovered.

#### KERATOSIS PILARIS.

In a mild form this disease is not uncommon, but may exist in such a slight degree that the physician is not consulted about it. The case to be described was diagnosed as above. The patient was only seen for a moment, during his visit to the city. Later he wrote me a description of the trouble, and the following is taken chiefly from that letter:

Aged 28. On arms, abdomen and thighs, papules average pin-head to small shot in size. "Sometimes red." At times they contain in center, "a little yellow matter," "and when they dry up a little yellowish ball can be squeezed out, this sometimes containing a hair curled within it." Eruption not grouped save on one arm. After bathing there is itching on limbs, and general itching if he *does not* bathe. Itching severe on thighs in summer, after undressing. Itches after a bath until skin circulation is re-established. No itching after a Turkish bath. Family history: Half sister died of consumption; no other cases. Patient is a blonde and robust. Slight blepharitis marginalis.

*Treatment.*—Ordered bi-weekly bath in water of temperature



of room, to each gallon of which half an ounce of cornstarch and two drachms of bicarbonate of soda were to be added, A. M. and P. M., and after bath to rub thoroughly with,

R. Ol. olivæ,  
Lanolin., aa ʒi.  
Saponis viridis, ʒvi.

M.

Internally he was to take emulsion of cod liver oil, beginning with teaspoonful after meals, and gradually increasing the dose to tablespoonful. The patient wrote rather disgustedly (*excusable*) of the treatment, but I encouraged him to keep it up, and two days later he wrote that it was "having a happier effect." This is the last record on the case.

#### POMPHOLYX.

*Two cases.*—First, gentleman of 29. Present about six years. Confined to feet, which sweat excessively and offensively. Constant formation of pin-head to pea-sized vesicles, between and "on" toes and on soles. After bathing and drying feet, marked itching. On inner side of left foot a round, defined, eczematous looking patch size of a silver dollar. General health robust. For "eczematous condition" was ordered

R. Ac. sal., gr. x.  
Ungt. zn. ox., ʒi.

M. Sig.—Keep constantly applied.

To keep feet thickly covered with the following:

R. Resorcin pulv., ʒi-ʒi.  
Acid. bor., ʒii.  
Amyli., ad. ʒiv.

M. Sig.—Dust well in socks.

Internally he received "Fowler's solution," two drops after meals, increasing dose at rate of one drop each succeeding day. Three days later, feet quite dry, itching better, one vesicle, eczematous condition improved. No further report.

Second case, gentleman of 45, with also seborrhoic eczema. Very large, deep bullæ flat, greenish looking, seated on toes and

soles. Pricking permitted discharge of yellow, serous fluid. Itching at borders.

R. Resorcin pulv.,  $\text{ʒiv}$ .

Zn. ox. pulv.,  $\text{ʒi}$ .

Amyli.,  $\text{ʒii}$ .

M. Sig.—Keep well dusted on. Wash feet at night in water containing a little soda. No more blebs formed, and patient was still well at end of three weeks, when last seen.

(*Alopecia areata, etc., next issue, and conclusion.*)

$1\frac{1}{2}$  Edgewood Ave.

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WHAT BECOMES OF DOCTORS AFTER GRADUATION.—In the *Medical Age*, Dr. W. R. Hubbert thus records the history of one hundred of his medical friends :

"I have endeavored to keep track of one hundred of my medical friends after graduation, especially of what they did during the first five years, and find nearly seventy-five per cent. had to resort to other employment to make a living. Twenty-three received a salary either in addition to practice or separate therefrom. Fifteen were proprietors of drug stores. Three were insurance agents. Four loaned money. One sold real estate. Three were connected with medical journals. One was an agent for drugs. One for books. One preached, One was in the patent medicine business. Two were farmers. One a manufacturer. Two gave massage treatment. One sawed wood, and subsequently suicided. Twelve gave up in disgust, and one never tried practice at all. Twenty-nine graduates only in one hundred exclusively devoted themselves to medicine, and of these, eleven associated themselves with other practitioners, and in many cases fell heir to their practice."

"In the western part of the county, that is, west of the Mississippi river, sixty per cent. of all physicians are connected with drug stores, either as clerks or proprietors. In the east the proportion is much less, being from twelve to fifteen per cent. In the west, also, forty per cent. of them have an interest in farms."

## **Society Reports.**

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### **GYNECOLOGICAL AND OBSTETRICAL SOCIETY OF BALTIMORE.**

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#### **THE MAY MEETING.**

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**DR. HENRY M. WILSON**, President, in the Chair.

**DR. BRINTON** read a paper entitled "A Day's Work in Obstetrics." Under this title he related the following cases:

1. A case of podalic version.
2. A case of normal labor.
3. A case of shoulder presentation; efforts at version unsuccessful; vagina ruptured; the woman dying undelivered.
4. A case of placenta previa lateralis treated by internal podalic version; mother and child saved.

**DR. MILTENBERGER:** There is some discussion in regard to the preference for high forceps and version. I prefer version, but the profession is divided, and the choice comes to a matter of skill and individual practice.

**DR. NEALE:** One of the points claimed for version over high forceps is that in version the narrower diameters of the head come first. It has been claimed that the same condition is brought about in the use of forceps by the diminution of the diameters of the crown, so that they are less than those of the base of the skull. I cannot see how this is, for certainly the forceps do not, as a rule, compress sufficiently to reduce the diameters of the crown to less than those of the base of the head.

Repeated attempts at version have often given bad results when the uterus is contracted and retracted, when there is a neglected cross-birth and the child is dead. After a moderate attempt at version has failed, decapitation should be done.

By means of Braun's hook it is certainly a comparatively easy and safe procedure.

I have no criticism to make upon the treatment Dr. Brinton adopted in his cases.

DR. BRINTON: Since this case of rupture of the vagina has been reported, it has been stated by a pathologist of this city that it is the only one on record. I would like to ask if any of the gentlemen present know of any such cases?

DR. MILTENBERGER: There are certainly on record many cases of rupture of the vagina. I have seen at least two such cases.

DR. THOMAS A. ASHBY: I once passed a sound through the uterus. The sound went in easily, and could be felt just below the umbilicus. Before this the patient had had pus running slowly from the uterus which had evidently had its origin higher up. There were no bad symptoms; the woman rode home, a distance of eight miles, and was not heard from.

I once attempted to remove an epithelial growth from the vagina, and all at once the intestines came down. I cleaned away the diseased tissue, closed up the opening with a firm stitch, and the wound healed promptly. The patient lived eleven months.

DR. GEORGE W. MILTENBERGER read a paper upon "Superfœtation and Superfecundation."

DR. P. C. WILLIAMS: I had a case recently of ovulation during lactation. A lady came to me who had continued to nurse her child and is now five months pregnant. These cases show that there may be ovulation without menstruation, and lead me to agree with Dr. Miltenberger.

DR. ASHBY: I have had cases similar to Dr. Williams. I have been surprised at the frequency with which menstruation returned after apparent removal of both ovaries and tubes. One of the first cases upon which I operated was one of hystero-epilepsy. I thought I had removed all the ovarian tissue, but found subsequently that I had not. She began to menstruate about eight months after the operation, and afterwards suffered from metrorrhagia. Three years later I examined her under chloro-

form, and found a small tumor. I operated and removed a small portion of an emptied ovary. She recovered promptly, and has not menstruated. Her health is good, and there has been no return of the hystero-epilepsy. I have had other cases in which some parts of the ovaries had been left behind. These women continued to menstruate. In those cases where I have succeeded in removing the ovaries entirely, I have not observed the return of menstruations.

DR. B. B. BROWNE: I attended a woman a few years ago who had had seven children, and had never menstruated. She was married before menstruation began, and had had children very frequently. I think superfœtation does occur. It certainly occurs in uterus septus.

The removal of the ovaries has little to do with the cessation of menstruation, but the tubes have much to do with it, and it is when a portion of the tube remains behind that menstruation continues. Metrorrhagia will occur when the tube is closed at the outer extremity. When a part of the ovary is left, of course a part of the tube is left also.

DR. W. E. MOSELY: My experience has been such as to make me believe that menstruation does not depend upon the presence of the Fallopian tubes, nor is it independent of the ovaries. Eighteen months ago I opened a lady's abdomen for a very severe case of chronic pelvic peritonitis, with double pyosalpinx. Both tubes were tied close to the uterus and removed, but after a diligent search no trace of either ovary could be found. Dr. W. H. Welch, to whom the specimens were shown, expressed the opinion that the ovaries had probably been destroyed in the inflammatory process. The patient made a good recovery after my prolonged drainage, made necessary by the sloughy condition of the pelvic contents and fecal fistula which persisted for several weeks. This patient, for months, has been menstruating regularly and freely every three weeks. In all probability, some portion of the ovarian tissue escaped destruction.

In another case in which I took especial pains to remove every particle of each ovary and both tubes, on account of severe hem-

orrhage, the patient has not had a show during the past twelve months.

DR. ASHBY: Mr. Tait has maintained the position of Dr. Browne for several years.

In one case the patient had been suffering from hemorrhage of tubal origin. I removed both tubes and one ovary. The other ovary having undergone cystic degeneration, it was impossible to remove all the ovarian tissue. This patient has been cured of her metrorrhagia, but has a normal menstruation.

DR. OPIE: It seems quite well established by *post mortem* results, that all cases of menstruation following oöphorectomy, are not due to failure on the part of the surgeon to completely remove the ovaries.

The utero-ovarian ligament, however, is sometimes very short, and the button-like section beyond the ligature, which, in such cases, contains ovarian stroma, may keep up a dominating influence. Again, the anatomical shape of the ovary gradually sloping off into the ligament, causes a part of the ovarian tissue to be left on the uterine side of the ligature in spite of the utmost care on the part of the operator.

The rule after childbirth seems to be that menstruation is in abeyance for a variable number of months, but cases have doubtless occurred in the experience of most obstetricians, when it has been uninterrupted during lactation. I have met with a number of cases where women have conceived during lactation, when there was no accompanying monthly flow. Dr. Tait thinks that during, and even after the menopause ovulation goes on, though the mucous membrane is disqualified for securing a fecundated ovule. Ovulation may be going on during lactation, but the mucous lining of the uterus may not be well qualified for menstruation or fecundation.

Dr. Bush, of New York, who has a dairy farm, has been performing some interesting experiments, to find out the mode of securing the best quality of milk. He has determined that the heifer, after the removal of the ovaries, can be made a perpetual milker, and that the milk is of better quality than in cows subject to ovulation and impregnation.

DR. BRINTON: With reference to menstruation after the removal of the ovaries, we have the statement that one or two per cent. of women have supernumerary ovaries, and possibly the return of the menstruation is due to the presence of the third ovary.

DR. MILTENBERGER: Dr. Browne laid much stress upon the fact that menstruation continued when obstructed tubes were present. Menstruation has nothing to do with the passage of the ovule along the tubes, but is due to the maturation of the ovule. Therefore, the tube may be obstructed as much as you please, and there will be no results. Batty and Engleman have reported a number of cases of pregnancy after the ovaries were apparently removed by skillful operators. In other cases, the ovaries, supposed to be removed, have been found *post mortem*.

DR. BROWNE: In most cases, where the ovary and tubes are removed, the lumen of the tube is obstructed by the ligation.

DR. ASHBY exhibited a specimen of a ruptured tubal pregnancy which he had removed from a patient seen in consultation with Dr. Arthur Williams, of Elk Ridge, Md. The patient was 34 years of age, and gave birth to one child ten years ago. She conceived in February of this year, and about the eighth week of gestation was seized with violent symptoms of intrapelvic hæmotel. Dr. Williams was called in and after examination diagnosed the condition as a ruptured tubal pregnancy. I saw the patient with him the following day, and upon examination confirmed the diagnosis. The patient rallied from the shock of the first rupture, and one week later a second rupture took place, though not followed with such violent and dangerous symptoms as in the first instance. The surroundings of the patient were so unfavorable that she was removed from her home in Anne, Arundel Co., to the Maryland General Hospital, where the laparotomy was performed. Upon opening the abdomen her pelvis was filled with bloody urine, blood clots, and evidences of general peritonitis. The omentum was in such a condition that it was found necessary to remove about three-fourths of the tissue.

The patient was critically ill from the 3d to the 5th day from symptoms of intestinal obstruction. Her bowels were moved by

administering one grain doses of calomel every hour for twelve hours, every other method having failed. The patient has made a successful recovery.

This is the third case of tubal pregnancy I have removed by laparotomy within the past two years, all of them having recovered.

WILLIAM S. GARDNER, M. D.,  
*Secretary.*

712 N. Howard St.

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## TRANSACTIONS OF THE GYNECOLOGICAL SOCIETY OF CHICAGO.

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REGULAR MEETING, MAY 22D, 1891.

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The President, Dr. W. W. JAGGARD, in the Chair.

DR. CHRISTIAN FENGER\* read a paper on "Ovariectomy during Pregnancy."

DR. KARL SANDBERG : I am very glad that Dr. Fenger has brought this subject up to-night, because it is one of great interest to all, and one that has not been discussed as fully as I think it ought to be. Dr. Fenger has covered the ground so thoroughly that there is not much to do except to indorse all he has said. As soon as we agree, and I presume that we all do, that ovariectomy is indicated in general in cases of ovarian cyst, the next point is to decide whether pregnancy constitutes any bar against this operation. Statistics show that the mortality of ovariectomy complicated with pregnancy is so far from being larger than the general mortality of ovariectomy that it really seems to be lower. Spencer Wells, in 1883, reported eleven cases of ovariectomy, with only one death. This would make less than ten per cent.

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\*See original article, page 458.



At that time, I think, Spencer Wells' general mortality was about twenty-five per cent. Lawson Tait reported about the same time eleven cases, also with one death, which would give about ten per cent. This is higher than his general mortality, but he attributes this one death to the use of the clamp, which was also used in the case of Spencer Wells' that died. Olshausen published last year a series of twenty-four cases of his own without a single death. Olshausen's mortality from ovariectomy in general is about ten per cent. Martin has some few cases without a death. All this goes to show that there is no greater danger in performing an ovariectomy during pregnancy than outside of it.

Furthermore, it is to be considered whether ovariectomy is possible in all cases where pregnancy is the complication. It has been laid down as a rule by Olshausen, and I think by Hegar and Kaltenbach, that small tumors impacted in the pelvis that do not seem to be movable contraindicate ovariectomy. I am extremely glad that Dr. Fenger has reported a case to-night of exactly this kind, where ovariectomy was performed with success to mother and child; it shows that this difficulty is only imaginary, it is only lack of courage on the part of the operator. I believe that all these cases can be operated upon by laparotomy, and the tumor can be removed; and if we have any doubt about it we ought not to cause a premature birth or tap a doubtful cyst through the vagina, as long as we can make a small exploratory incision and ascertain just what the condition is. It appears from Dr. Fenger's report that even in those cases where the tumor is impacted in the pelvis under the pregnant uterus, the uterus can be lifted up and turned out, the tumor removed, the pedicle secured, and the operation finished in good shape. But even if the tumor could not be lifted out, I do not see any great obstacle to tying the pedicle at the bottom of the pelvis with a long-handled, blunt needle, tying and cutting as you go along.

An objection has been made to this operation because of the number of cases resulting in abortion afterwards. This seems to be a little different with different operators. Spencer Wells, in

his first list, had one case where he did not expect pregnancy and tapped a pregnant uterus. He made a Cæsarean section, removed all the contents, and sutured the uterus. That cannot be counted in, but of his other ten cases three aborted. In one he secured the pedicle with a clamp, and the patient aborted about ten hours afterwards, and died; he had another case that aborted six days, and one that aborted twenty-five days after the operation—that makes three out of ten. Lawson Tait reports eleven cases uniformly successful. Olshausen, on the other hand, seems to have had several abortions. In his first eight cases he reports two abortions. In his whole series of twenty-four he does not give the number, but says that some aborted right after the operation and some a few weeks or months after, and he ascribes it in all the cases to the operation. Hegar and Kaltenbach give the percentage as about forty, without giving the sources from which they draw this conclusion. I get the impression from this that the number of abortions resulting from this operation is, and will be, different with different operators. It was doubtless so that in Spencer Wells' case the use of the clamp caused immediate abortion, which we can understand on account of the traction on the pedicle. We will probably find in the future that some operators who have a large percentage of abortions in the performance of the operation adopt some procedure which is to blame for this. But even if we admit that there are a great number of abortions, the fact that in a great number of cases the operation can be performed without abortion occurring is sufficient to do away with this objection, because, in the first place, it has been proved by Olshausen that abortions do not increase the mortality, and, in the second place, if we do not do ovariectomy we will have to depend upon the production of premature labor as the principal means of getting over the obstacle.

In conclusion, I congratulate the society upon the fact of this excellent paper being read here, and I most heartily indorse the views of Dr. Fenger.

DR. A. REEVES JACKSON: My experience in the removal of ovarian cystic growths during coexistent pregnancy comprises

two cases, which I will briefly relate. Some years ago a woman was placed under my care with enlargement of the abdomen of a doubtful character, and which was supposed by her physician to be due to hydramnios. She had been married twice. Her first marriage was childless, and after a widowhood of three years she married again. Menstruation had been regular up to six months prior to the time at which I saw her. Then it had suddenly ceased and she supposed herself pregnant. Prior to the cessation of menstruation, however, a tumor had appeared in the left side of the lower abdomen, and had attained about the size of a cocoanut. After menstruation ceased there was very rapid distention of the abdomen, and, inasmuch as the tumor could not be clearly distinguished, the enlargement was attributed to dropsy of the ovum. At the time of my examination the abdomen was enormously distended; the enlargement was symmetrical and seemed to occupy the entire abdominal cavity. The walls of the abdomen were thin, traversed by enlarged vessels, and the umbilicus was protruding.

From the history which was given of the rational and sympathetic symptoms of pregnancy which had occurred during the first three months, and the condition of the os uteri, which was easily within reach, I felt satisfied that the patient was pregnant and that she had also ovarian cyst together with some free abdominal fluid. Her condition at that time was an extremely critical one and the symptoms urgent. I was, however, reluctant to interfere in a radical way so long as it seemed that she might go on to the full term of utero-gestation. There were some unusually cogent reasons why she should bear a living child. But the symptoms in a few days became so much more alarming that I concluded to tap the cyst, which I did, removing by a small trocar some gallons of fluid having a soap-and-water appearance. She was relieved at once, and after the operation the uterus could be distinctly felt rising up to within an inch and a half of the umbilicus, and at the lower left side was distinguishable the basic portions of the tumor, consisting of numerous hard nodules, clearly corroborating the diagnosis of multilocular ovarian cyst.

In the course of six weeks the abdomen filled again, with even greater rapidity than before, and she was so emaciated and suffered so greatly that I felt it to be unsafe to longer defer operation. Accordingly I removed the cyst. The patient got on well in every way, but five days afterward labor set in, and she was delivered of a child developed to about eight months, which survived. She recovered after a rather tedious convalescence and has subsequently borne two children. In this case the pregnancy was known to be present, but in the second case on which I operated the pregnancy was not known—not even suspected. In June, 1888, the wife of a clergyman, 30 years of age, was brought to this city from Lincoln, Neb., suffering from a rapidly growing cyst which had commenced in the right side. It was clearly defined, and gave the impression of being a tumor which might weigh four or five pounds. The patient suffered severely from pain, which had commenced about nine months before. I learned subsequently that she had ceased menstruating two months before I saw her. I had no hesitation in at once removing the tumor. At the time of the operation the uterus was found somewhat enlarged and presenting the appearance of pregnancy, and I expressed the belief that the pregnancy was two and a half months advanced. The patient recovered, went home, and was safely delivered of a living child in the early part of the following December.

With regard to the propriety of removing an ovarian cyst during pregnancy, I hold that the decision should depend upon the circumstances of each case. It should not be done because pregnancy coexists; on the other hand, the operation should not be withheld because of accompanying pregnancy. Usually in a case in which interference becomes necessary, and a choice could be made, I should prefer to remove the cyst rather than to induce premature labor. I deem it the safer operation of the two. Nevertheless, when it may be safely done, I should defer ovariectomy until the fetus had attained viability. I cannot agree with the opinion expressed here that it is less dangerous to remove ovarian cyst during pregnancy than under other circumstances.

I believe, on the other hand, that any important abdominal operation is likely to induce premature labor or abortion, and hence, unless the symptoms were urgent, I should defer operation until some necessity arose. Some of the statistics which have been adduced here to-night are misleading, because they give the impression that ovariectomy is made safer by pregnancy. I cannot accept this. If a sufficient number of cases were known I feel confident that the results would not lead to this conclusion. In the case related by Dr. Fenger there could be no question about the propriety of removing the tumor. There was a cyst of dermoid character so situated as to be liable at any time to give rise to dangerous complications from the bursting of its walls. Such a result would be almost certain to occur during labor. But when the cyst is found occupying such a position as not to interfere with labor, it may be properly let alone until after parturition. I am very glad that this paper has been brought before us. The statistics gathered here are exceedingly valuable, and personally I thank Dr. Fenger for presenting the subject.

DR. A. H. FOSTER: I would state that during the temporary absence of the attendant I was called to a case of labor, in an old patient of mine who had lived with one husband for several years without having become pregnant. By reason of some incompatibility of body or mind the parties separated, and she had married a second time, and this was the fruit of the union. I found that one of our Fellows had done ovariectomy upon her when she was some two months advanced, but I do not know the particulars of the case. Our lamented Dr. Parks had treated her, knew about the case, and had followed it up. The labor, which was a forceps case, was very difficult. I have been called to the family only once since, and then in a great hurry this last winter, and found the child living and doing well.

DR. FRANKLIN H. MARTIN: I simply wish to put a case on record. The first laparotomy I performed was in 1883. The patient, aged 30, presented the following symptoms: She had not menstruated for three months. During the time that menstruation should have occurred the pain was intense and there she had epilep-

tic fits. The patient was examined, and a diagnosis of pregnancy made. About two and a half months afterwards a tumor was discovered to the right of the uterus about the size of a cocoanut. The discovery of this tumor so changed the aspect of affairs in my mind that pregnancy, while previously admitted, was really lost sight of, and I decided to perform a laparotomy. I made my preparations as liberally as preparations were in the habit of being made in those days, including steaming and thorough renovation of the house in which the patient was to be operated upon. I was assisted in the operation by Drs. McArthur, Bishop, Doering, and others. The abdomen was opened, and a tumor about the size of a cocoanut to the right of the ovary discovered, together with a confirmation of the pregnancy. The tumor was removed, the abdomen closed in the ordinary way, and the patient put to bed. She did fairly well until the fourth day, when she aborted with a fetus of about four months. This was my first laparotomy. I started in with the idea of doing one hundred laparotomies without a death. At the end of the sixth day after this operation my mortality in abdominal surgery was one hundred per cent., the patient dying of acute sepsis.

DR. CHRISTIAN FENGER, in closing the discussion, said: I thank the Society very much for their kind reception of my paper. There are, of course, a number of questions pertaining to this matter which I have been unable, on account of lack of literature, to go thoroughly into. For instance, the question, shall we make a distinction between tumors in the small pelvis and tumors in the abdomen; is there any choice of action when a tumor is located in the small pelvis; shall we wait and not do ovariectomy under certain circumstances? Tumors in the small pelvis, I think, indicate, as Schroeder says, immediate operation. These questions can only be solved by having observed a sufficient number of cases where both of these classes of tumors were left until the end of pregnancy, so as to see the real danger of each of them. I had hoped that the obstetricians, who have seen a large number of labors, might give us some of their experiences in this respect, and thus help to solve that part of the question.

## Correspondence.

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### OUR NEW YORK LETTER.

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NEW YORK, September 19, 1891.

Medical matters have been peculiarly stagnant in New York this summer. There have been no medical meetings, no startling discoveries, and even the customary summer diseases have not been so prevalent, in spite of the fact that several miles of streets have been constantly dug up by the railroad and gas companies.

The house to house visitation in the tenement house districts, by physicians of the Health Department, has been prosecuted as usual during the hot season. This work has already borne good fruit here, and is worthy of imitation by other large cities. The corps consists of fifty physicians, to each one of whom is assigned a district. Within this district, it is his duty to visit each family living in a tenement house and ascertain the sanitary condition of the premises and of the different apartments, the habits of the people in reference to sanitary matters and the care of their children, and in cases in which the family is too poor to pay a physician to attend any who are sick. The importance of such work in this city can only be thoroughly appreciated by those familiar with the crowded condition of some of the districts, and the uncleanly habits of the people. The recent influx of Russian Jews has crowded parts of the city to a point beyond anything in any civilized city in the world. These people and the Italians are uncleanly to a degree. Sanitary regulations are of little avail, and even the constant personal supervision of a health officer hardly prevents their quarters from being pest-breeding nests. Much good in the aggregate is, however, accomplished by the

summer corps. Many children are saved by the prompt treatment of what the mother regards as an insignificant diarrhœa or cough, and the continued distribution of circulars giving instructions concerning infant feeding has brought a more intelligent understanding of this subject among the poor and ignorant. The result of this is beginning to be noticeable. The usual plan of treatment of moderate diarrhœa is to correct errors in the feeding, which I may say is found in the large majority of cases, and give a powder containing one grain of pepsin, two grains of bismuth and two of aromatic chalk powder every two or three hours. As an adjunct to this treatment sea air is generally added. This is obtained by means of the Floating Hospital of St. John's Guild. This hospital consists of a large barge which has been fitted up for the purpose. It carries physicians and nurses, and every means is provided for the care of the sick. The barge is towed down the bay in the morning and remains there all day, returning in the evening. As many as 1,600 mothers and children are taken on a single trip.

Another duty of the visiting physician, and a more difficult one, is to instruct the people in sanitary matters. Advice regarding the cleaning and ventilating of rooms, the disposal of kitchen refuse, the airing of bedding, etc., is offered, and in some cases its practical adoption must be enforced at the moment. This is the most difficult matter to contend with in all the sanitary reforms. It is hard to alter the habits of the individual. The problem must be solved by the force of example, the distribution of literature bearing on the subject, and the instruction of children in the public schools. The natural advantages of New York ought to render it one of the most healthful cities in the world, and yet the death rate is as high as that of any large city in the temperate zone.

#### IMPETIGO CONTAGIOSA COMPLICATING VACCINATION.

A skin eruption unusual in its severity, if not in its nature, has been seen attending vaccination in a few cases in this city. One of them chanced to come under my own observation, and a description of it will suffice for those of the others of which I have heard.



It was in a female child of five years of age. She was vaccinated by a health officer in June, and nothing unusual occurred until the pock was fully developed. Then a few blisters appeared in the neighborhood of the pock, which were soon followed by others on other parts of the arm. Then the other arm became affected, and eventually every part of the body, including the face and scalp, was the seat of the eruption in some stage. The vaccination ran the usual course. The patient was not seen by me until five weeks after being vaccinated. There was then nothing to be seen at the seat of vaccination except a scar. The limbs and body of the child, however, presented a striking appearance from the presence of a wide-spread eruption distributed in pronounced outlines. The groupings were principally, although by no means wholly, confined to the flexor surfaces of the arms, the backs of the legs, the inside of the thighs, the genitals and buttocks; a broad girdle encircled the neck, while the chest and abdomen were entirely free. On close examination the eruption was seen to be bullous in character, the lesions varying in size from two pins' heads to a lima bean, most of them being about as large as a green pea. Where the more pronounced configurations were, the surface was generally reddened and irregularly crusted. On this reddened surface where lesions had just recovered, new blebs were developing, some small and filled with clear fluid, others larger and more opaque. The lesions were usually discrete, but in some instances several had run together, a crusted mass resulting. When this was removed the surface was found excoriated but not ulcerating.

Dr. Geo. T. Elliott, the well-known dermatologist, who saw the case in consultation, drew my attention to the tendency of these patches to spread at the periphery in a serpiginous manner, thus causing the map-like configuration which made the child such a striking picture. Discrete bullæ were also found in the midst of an area of sound skin. They stood out like beads, there being not even a red line of inflammation around them. When these disappeared, which they did by drying into a crust, after rupturing, a red mark was left. The eruption itched fear-

fully, and the child's health was reduced from the discomfort and broken rest. The case was regarded as one of aggravated impetigo contagiosa, beginning with the vaccination, and spreading principally by anti-inoculation by means of scratching. Free lathering with ichthyol soap was advised by Dr. Elliott, a plan of treatment which relieved the itching immediately and was soon attended by marked improvement. The new lesions became fewer in number and smaller in size, and the child's general health improved very much.

After two weeks a relapse occurred, presumably because of the very hot weather then prevailing. An occasional bath in solution of bichloride of mercury, 1 to 10,000, was then added to the treatment, and ichthyol was used in carron oil instead of soap. The result was not satisfactory, and the use of soap was renewed. About four weeks ago, when again improving, the child was attacked by scarlet fever. The germs of the two diseases appeared to agree amicably, for both eruptions thrived equally well. The impetigo lesions were slightly modified, however, in that they were more inclined to become milky and were surrounded by a narrow zone of inflammation.

At present writing the eruption is still present, but is improving under the soap treatment. It is most persistent about the genitals and internal surface of the thighs, where new lesions crop out in clusters in spite of treatment.

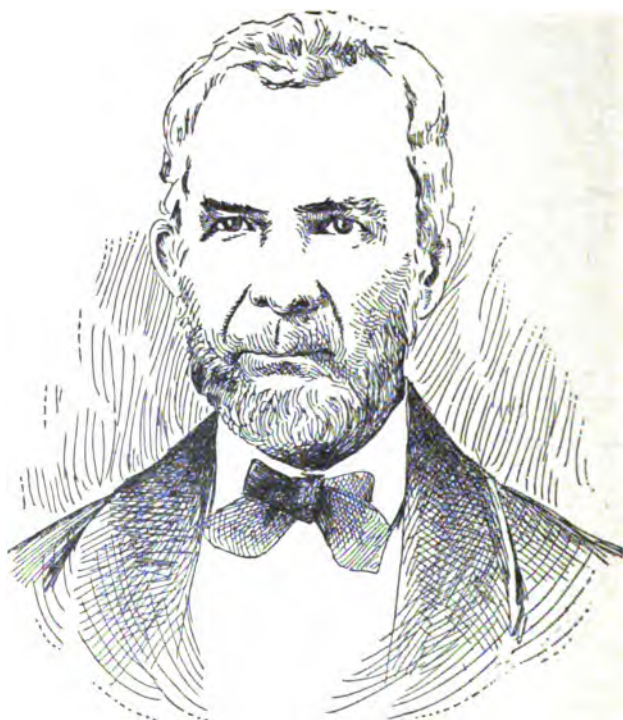
The histories of two other cases which have been related to me corresponded essentially with the above. The eruption persisted for four or five months, but eventually disappeared.

151 *East Fiftieth Street.*

WM. L. RUSSELL.

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The Mississippi Valley Medical Association will convene in its seventeenth annual session, St. Louis, October 14, 15 and 16, 1891. The officers are : President, Dr. C. H. Hughes, St. Louis; Secretary, Dr. E. S. McKee, Cincinnati; Chairman Committee of Arrangements, Dr. I. N. Love, St. Louis.



HENRY GAITHER, M. D.

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IN MEMORIAM.

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The subject of this sketch was born near Sparta, Hancock county, Georgia, August 8th, 1801. His father was a native of Maryland, and his mother was from Putnam county, Georgia. He received a good country school education, and then an academic training, under the celebrated Alonzo Church, D. D., previous to his elevation to the Presidency of Franklin College, Athens, Georgia. He served in a country doctor's shop; and

afterwards went on to New York and became, when quite a youth, a private pupil of the late distinguished and lamented Dr. John W. Francis, of New York City. Subsequently he matriculated in the medical department of the University of Pennsylvania. As a student by competitive examination he became a member of the Medical Society of Philadelphia. After completion of his medical education in Philadelphia, he came to Georgia and began the practice of medicine in Covington in 1825, and after a few year's practice, he took in as junior copartner the late Dr. A. Means, who was the older man, but younger physician. In 1844, he moved to Oxford, Georgia, having been previously elected trustee of Emory College, which place of trust and honor he held as long as he lived. *He never missed a roll call up to the 49th*, that being the last. He joined the Medical Association of Georgia in 1851, two years after its organization; and was an honorary member at the time of his death. The *ad eundem* degree was voluntarily conferred on him by the Medical College of Georgia, at Augusta; it was also done in the same way by the Atlanta Medical College. In April, 1880, the Medical Association of Georgia, at its 31st annual session, held in Augusta, elected him first on the list of delegates to the American Medical Association, at its approaching meeting in New York, in company with Dr. Robert Battey, Henry F. Campbell, J. P. Logan, K. P. Moore and others. He was an *ardent* member of the Medical Association of Georgia, from 1851, the time he joined it, until January 27th, 1891, at which time he passed from among us, surrounded by physicians, family and friends. These two dates—August 8th, 1801, January 27th, 1891, nearly ninety years—embrace a period with him of *no common* living, *for in most* respects he was a very extraordinary man. As Bishop Haygood said of him, "He was brave and heroic, and his sweet spirit, his gentleness, his loving kindness, was the victory of a strong man who, at last, through the grace of God, had triumphed." He possessed property sufficient to have caused many to turn back from the ordinary duties of a village and country doctor, in those days of long rides, by day

and by night, over rough roads; and most of the time with no counsel, having to depend entirely upon himself. But he was not of that *stuff*. He loved his profession, and he loved his fellowman and I have often heard him say that "it was as much his love for man, as his love for his profession, that kept him in the trying duties of a country doctor at that time." Fidelity was his motto. Punctuality was *uppermost* in his mind, believing it to be the first element of success in all business. He would be impatient with his best friend, who lacked in this important part of a doctor's make-up. He kept aloof from all office-holding or office-seeking, both civil and military. Refused many times to hold office, keeping an eye single to the study and practice of his profession; and to use his words, "that was sufficient to fill his hands, his head and his heart."

He was a clear, sharp, ready, diagnostician; and thought through a case rapidly, but almost invariably correctly, allowing nothing in the words of the patient or surroundings to keep him from "going to the core of the case," as he expressed it. And after making up his mind, he was firm in his diagnosis and treatment, and would not suffer any deviation in essentials from his plans.

He had no patience with secret nostrums or patent medicines—*was bitter*, and justified himself by saying, if he assumed the responsibility of treatment, he *must know* what he was giving, and would stand by his own prescriptions. He hated charlatanry in all of its forms. He was ever busy in his office, or at the sick bed. He had a contempt for a loafing, gossiping doctor. He had a vein for the humorous, was cheerful and courteous. For pleasure trips and vacations he had but little use, saying, he needed no vacation, he "made a pleasure of business." He was a constant reader of medical journals and also of general literature. He kept up with the profession, not only in reading, but in practice. He had a singular and wonderful gift in selecting from the myriads of new remedies, such as were really useful. At the same time, he would not give up the old things that he knew to be good. Humorously speaking, I used to amuse and at the same

time gratify, him, when I said, "I would like to take his picture as an M. D. of sixty-five years of continuous practice with a *thumb lancet*, *fly-blister* and *calomel* in one hand, and a *hypodermic syringe*, *clinical thermometer* and *phenacetine* in the other.

He claimed that the use of stimulants, both in acute and chronic diseases, was rarely necessary; and prided himself that he had "never made a drunkard by the careless use of alcoholic liquors in sickness," saying, "it was better to die a young sober man than an old drunkard." Again, he held that "*no man in health needed stimulants*" to do his work, arguing that the proper use of food and rest, and if necessary, slacking in your work, rather than whip your system up beyond its power, to wear out that much the sooner. Yet he would use stimulants in selected cases. He was wonderfully practical, and used to say that his "mechanical turn had *stood* him good service in treating fractures and other surgical work." Again he was ready to be useful (especially, in the earlier days when such help was more needed than now) in writing wills, or even holding religious services with his patients. I have heard him say he had been "physician, priest and lawyer." For while he was as modest as a woman in his religious pretensions, he was as clear in his faith in the doctrines of christianity as he ever was in any principle in law or medicine. It was not a lowering of his dignity as a doctor to be an honest unpretentious believer. I *never* saw this more clearly exhibited any where than in Oxford, December 29th, 1881, when he had the misfortune to break his right femur from a fall on the back steps of his residence. They were wet and slick from a recent shower of rain, and he had a bucket in one hand and a cup in the other, going to water the flowers in the conservatory. At his age, over eighty, he knew the uncertainties of such an accident, the confinement, etc. But as I entered his room, some little time after, I found him pale as death from the shock, and a clammy sweat on his brow, yet his dark, bright eyes shown with unusual brilliancy, and he had a calm, peaceful, happy expression on his face, and his words abounded in praise to God, for he said, "he accepted it as from him, he did not doubt but that

it was in answer to his own prayers, although he had never prayed for his limb to be broken, yet he had asked God to do what was best for him." His wonderful self-possession and readiness in practice were vividly shown in the manner in which he had himself engineered into his room after his fracture. He then called for the yard-stick and took the measurement for the splints himself. Later on he gave directions as to the treatment of his case. Thus exhibiting what one who knew him well had said, that, "while he was faithful and true in all cases of sickness, no matter how common or trivial the complaint, serious diseases and injuries, instead of intimidating him, urged him the more to use the best of his faculties, and as the case progressed he rose with it."

He wrote occasionally for THE ATLANTA MEDICAL AND SURGICAL JOURNAL and other periodicals, and always short, clear and decided articles. No one was ever in doubt as to what he meant, when he wrote or spoke. While his opportunities for early education were meager, he was an educated man, for he had, as Bishop Haygood wrote of him in his obituary, "a ready and masterful use of his faculties." The Bishop also says, "Few men have I known whose fine senses were better trained to quick and accurate observation; he really saw with his eyes and heard with his ears. If his active habits had not been broken up by the breaking of his thigh nine years ago, that vigorous, closely knit frame would, I believe, have done service for more than a hundred years." He did not look or seem to be near as old as he really was. He was in the habit of saying that "he was just as young in his *sympathies, sensibilities and affections* as he ever was in his life."

He was married twice, first to Miss Sarah Cole, of Greene county, in 1827, and afterwards to Miss Julia A. Fraser, of Marietta, Georgia, in 1871. His success as a physician, surgeon and obstetrician was remarkable—always taking punctually, cheerfully and confidently every case of suffering humanity.

While he honored the great specialists in medicine, he was not ashamed of his place in the rank and file of a general practitioner;

holding that while the former deserved praise for consummate skill, the latter deserved none the less for his success in all its branches. The poor he always loved to administer to. He often repeated with *emphasis*, as expressing his views, that notable saying of the late lamented Prof. Joseph A. Eve, M. D., LL. D., of Augusta, Georgia, who said to a graduating class, "*I always want some poor patients.*" He used to say, "The lowest bows I make are to the unpretentious in humble life, and to the good in all the walks of life. But for the man who thinks more highly of himself than he ought to think, I have *no special conges to make.*"

For nine years after his fracture he was more or less confined to his house, but his uncomplaining spirit, cheerfulness of disposition, and interest in all things was marvelous; and he kept his faithful and devoted wife lovingly busy in reading to him the medical and miscellaneous journals of the day. Physicians sought his counsel in grave cases to the last, and he thus gratified his own feelings and helped others, in doing as he said he intended to do, "*practice to the last.*"

If the above sketch should appear to some lengthy and over-drawn, the writer pleads that for its length he hoped by its contents to encourage the younger members of the profession in giving them the secrets of success in "a rare old man who had triumphed. And as to the truthfulness of what I have written a daily medical copartnership of twenty years ought to justify me in knowing and so speaking.

W. W. EVANS, M. D.

Oxford, Ga., Sept. 3, 1891.

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Every week the *Scientific American* presents whatever is new in the world of science, art and manufactures, thus doing service both to theoretical and practical workers. For forty-five years, Munn & Co., 361 Broadway, N. Y., have conducted this paper with close reference to the work of procuring and describing patents in a way to make it an authority on scientific and mechanical subjects.



# Editorial.

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## TO OUR READERS.

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*The aim of the JOURNAL is to furnish matter which will interest its readers, and its policy is to get the best matter available. In pursuance of this policy we introduce a new feature.*

*We desire our readers to write out briefly, and in a practical manner, their method of treating the diseases which shall be mentioned at the head of this page.*

*As the season for "COMMON COLDS," or CATARRHAL FEVER, will be present for the next few months, we beg you to send in a description of your method of treating this sometimes troublesome ailment. Your letters will appear in order as received.*

*With this, the first issue of the present fiscal year, we send out our regular annual statement to subscribers. We hope these reminders may meet with a ready response at the hands of our patrons.*

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## MEDICAL WORDS.

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The *Medical News* initiates a reform in the spelling of certain words, which we think, on the whole, very commendable. The medical editorial staff of the *News* hereafter will use the simple *e* for the older form, *æ* and *œ*. Thus: Hemorrhage, Anesthesia, Etiology, Esophagus, Cecum, Gonorrhea, etc., etc. It is not yet brave enough, however, to change Cæsarean, Nævus, Amœba, Pharmacopœia, etc.

Speaking of orthography suggests etymology, and here we wish to raise our voice in protest against a word which has, of late years, crept into the language. Whatever else may be said of *electrocution*, the word itself is all wrong, just as *vulvitis*, *ovaritis* and *antifebrin* are wrong. These are hybrids, bastards, deformed and misshaped. Rockwell proposes *electro-execution*, which is not very much of an improvement, notwithstanding the hyphen. *Electrothunasia* is suggested by Peterson, and this seems to answer the requirements of etymology and euphony fairly well. But that it will ever be pronounced "trippingly on the tongue" we seriously doubt.

# Selections.

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## CHLORALAMID.

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By EMORY LANPHEAR, M. A., M. D.,  
Professor of Orthopædic Surgery in the University Medical College.

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### EXTRACT FROM A CLINICAL LECTURE.

This comparatively new medicinal agent is prepared by combination of two parts of chloral anhydride with one of formamide; it is found in commerce as a colorless crystalline substance, nearly tasteless, soluble in about twenty parts of water and two of alcohol. It will keep indefinitely in solution without decomposition, but cannot be dissolved in hot solutions because of chemical changes. It acts very much like chloral and sulphonal, but does not depress the heart like the former, and is much superior to the latter in that it is soluble, exerts no bad influence upon digestion, possesses no diuretic action, never causes pruritus, vertigo, diarrhœa, or other bad symptoms which sometimes follow the administration of sulphonal—in fact, experience is demonstrating the accuracy of Reichmann's observation; from chloralamid no ill effects in the circulation or in the feelings of patients are to be noted, and besides, the cost is much less than that of sulphonal. T. Lauder Brunton, in a recent report on the Relative Utility of Different Hypnotics, highly commends it, and states that with reference to certainty of action and the question of tolerance chloralamid excels.

It exerts its influence upon both the brain and spinal cord, producing sleep and reducing the motor excitement; it may be regarded as a pure hypnotic without anodyne properties, though some late reports would indicate that it has to some degree the power for partial abolition of pain. It is, then, the ideal seda-

tive, giving prompt and satisfactory action, reliable results and absolute freedom from evil side or after effect.

Its dose is from fifteen to sixty grains. The proper method of exhibition is to give fifteen to thirty grains (according to the condition of the subject), repeating the dose in an hour if the first has not produced sleep; usually from ten to thirty grains give five to eight hours' refreshing slumber. The best method of giving it is to dissolve the required amount in about a teaspoonful of whiskey or brandy, or in a small glass of wine if the patient prefer. It may also be given in anything containing alcohol in considerable quantities, as tincture cardamon compound, tincture of hyoscyamus, etc. If for any reason it cannot be given in this manner it may be taken in powder form, and washed down with cold water or cold tea. The direction of W. Hale White, of London, is a good one, viz., tell the patient to dissolve the powder in brandy, add water to his liking, and drink it shortly before going to bed; this combination with spirits is particularly good in our surgical cases where whiskey is usually indicated, at least, in most major operations. If in any case it be better to have the medicine in liquid form, this combination may be prescribed:

R. Chloralamid,  $\mathfrak{z}$  ij.

Spts. frumenti, fl.  $\mathfrak{z}$  i.

Misce bene ut ft. solut. et adde :

Syrupi rubi ideai fl.  $\mathfrak{z}$  i.

Misce. Sig.: Dose, one tablespoonful, to be repeated in one hour if sleep is not produced. This makes a decidedly pleasant mixture of slightly acid taste and fruity aroma and flavor.

*Kansas City, Mo.*

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ON TAKING FLUID WITH MEALS.—A great deal of misapprehension is often found to exist in the popular mind in regard to matters of eating and drinking; the cause of this, to some extent, is to be traced to old-time sayings which have come down to us in the form of a concentrated infusion of somebody's opinion

upon a subject of which he or she was woefully ignorant. One of these misapprehensions to which we may refer is as to the injuriousness of taking fluid with meals. One frequently hears it laid down as a maxim that "it is bad to drink with your meals, it dilutes the gastric juice." By way of explanation we may remark that "it implies that the fluid taken is harmful." Whence this sagacious postulate originally came we cannot tell; it has quite the ring about it of an inconsequent deduction formed by a person whose presumption of knowledge was only exceeded by a lamentable ignorance of the subject. Medical men often find much difficulty in dealing with these museum specimens of antiquated science, for even educated persons are disposed to cling to the absurdities of their youth. Upon this matter Mr. Hutchinson remarks in the last number of his "Archives": "I observe with pleasure that the verdict of general experience and common sense has been confirmed by scientific experiment in the matter of taking fluid with meals. Dr. Tev. O. Stratievsky, of St. Petersburg, after elaborate trials, has found that fluids materially assist the assimilation of proteids, and announce the following conclusion, which it is to be hoped no future experiments will controvert: "On the whole, the widely-spread custom of taking fluids during or just before one's meals, proves to be rational and fully justified on strict scientific grounds. To take fluids with the meals is almost as important an adjunct to digestion as is the mastication of solid food preparatory to swallowing it." It is obvious, however, that there is a limit to the amount of fluid one can swallow with impunity—not to speak of comfort—just as much with meals as at other times. It would be dangerous to create a general impression that fluid is good with food irrespective of quantity. It is, moreover, a well-ascertained clinical fact that an excess of cumprandial fluid does retard digestion in certain people, and gives rise to discomfort in most. A little attention to one's sensations in such matters will far better fix the desirable limit than all the "data" in the world.—*Medical Press and Circular.*

**THE THERAPEUTIC VALUE OF INDIAN HEMP.**—I have during the last few years been accustomed to prescribe Indian hemp in many conditions, and this drug seems to me to deserve a better repute than it has obtained. In one form of insanity, more common in women than in men, and brought on usually by mental worry, often owing to the illness of a near relative or by a moral shock, the drug acts almost as a specific. In this affection the patient is depressed and apprehensive, she imagines that animals are after her or that some one wants to injure her. There is great mental confusion and mental loss, the patient is unable to carry on any conversation, and sometimes is unable to dress herself, the condition being one of acute dementia. I have notes of several such cases that have been cured by Indian hemp within a fortnight. I usually give 10-minim doses of the tincture thrice daily, combined with iron and strychnine. I prescribe also complete rest and plenty of food. The Indian hemp is an essential factor in the treatment, for without it the rapid recovery does not ensue; it seems to remove the mental distress and the restlessness.

Indian hemp has proved very useful in my hands in the treatment of melancholia and mania. I have also found this drug of great value in the treatment of chorea when arsenic fails, as it frequently does. It may be combined with chloral with advantage in such cases. In migraine the drug is also of great value; a pill containing  $\frac{1}{4}$  gr. of the extract with or without a  $\frac{1}{4}$  gr. of phosphide of zinc will often immediately check an attack, and if the pill be given twice a day continuously the severity and frequency of the attacks are often diminished. I have met with patients who have been incapacitated for work from the frequency of the attacks, and who have been enabled by the use of Indian hemp to resume their employment. This drug is also a valuable gastric sedative in cases of gastric ulcer and gastrodynia. It may be combined with nitrate of silver, and it increases the efficacy of the latter. Its value is well known to asylum physicians, but it does not appear to have obtained the confidence of the profession generally. Indian hemp is also a very valuable hypnotic.—C. W. SUCKLING, M. D., *Brit. Med. Journal*.

**ALCOHOL—INFLUENCE OF INEBRIETY UPON THE OFFSPRING.**

—A very important contribution to the alcohol question has just been furnished by Prof. Demme in Bern, in his inaugural address published by Fred Enke. The title of this substantial paper is: "The influence of alcohol on the organism of children." It is founded on personal investigations and experiences, numerous clinical observations and partly on experiments in the Pharmacological Institute of Bern. The author proves in an irrefutable manner that spirituous beverages, taken even in moderate quantities, have a much more injurious action on the juvenile organism than on the adult, and that severe disorders, especially of the nervous system, directly connected with early use of alcohol, are frequently demonstrable in children. (Diminution of longitudinal growth, promotion of rachitis, epilepsy, chorea, nervosity, cirrhotic processes, etc.) As especially injurious are pointed out alcoholic beverages given between meals, the author has ascertained repeatedly by examination of the gastric juice, whereby obstinate stomachic catarrhs with tumefaction of the abdominal lymphatic glands and increasing loss of forces are caused.

As an illustration of the fact that inebriety of parents injures enormously the vitality and health of their offspring, which is also transmitted very frequently, Prof. Demme relates the history of 10 drunken families, observed by him since 1878. Of their 57 direct descendants, 25 died in the first months of their life (general debility, eclamptic accidents, etc.); six children were idiots, five strikingly small, five epileptic, one affected with chorea and lastly idiot; five children were affected with transmitted diseases (hydrocephalus, harelip, etc.) Ten children only, i. e., 17.5 per cent were in a normal condition. On the other hand, the descendants of ten families of very moderate habits of life, observed as a comparison, were men of normal constitution, intellectually and bodily in the proportion of 81.9 per cent.—*Pacific Record*.

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**WIRING OF THE VERTEBRA.**—Dr. B. E. Hadra, of Galveston, Texas, has wired the vertebra for fracture of the spine, and sug-

gests the same operation as a means of immobilization in Pott's disease. (See *Times and Register*, May 23d.) In cases of fracture the wire sutures simply retain the fragments in close apposition ; in Pott's disease, the author thinks this method would fix the vertebra better than other methods now employed, and thus offer a better protection to the cord. It is also less annoying to the patient. The steps in the operation are as follows :

"A good long incision, the centre of which should be over the seat of fracture ; next the muscles on either side of the spinous processes should be lifted up and drawn aside with blunt instruments, but not more than to allow one to feel the contours of the bone, then a stout curved needle, armed with wire, is carried through the interspace between the spinous process of the broken vertebra and that of the next upper one, as deep as possible ; brought out, entered again into the next inferior interspace ; brought out on the other side ; entered there again into the next lower interspace ; carried around the spinous process of the vertebra, below the fracture, and again carried through the middle interspace, and, meeting the wire where it entered, well twisted together to a knot. In short, a figure-of-8 loop is carried around the spinous processes of the broken vertebra and that of the next lower one, which may be repeated as often as seems advisable. In the lumbar portion of the spine simple loops will suffice, as the processes are almost horizontal. Then the wound is closed, with or without drainage."

As yet, Dr. Hadra has operated only once, and the result has been highly satisfactory. He mentions a case of a new-born child operated upon by Dr. Wilkins, in which the last dorsal and first lumbar vertebra were separated by an interval of half an inch. The spinous processes were fixed together by the figure-of-8 suture, and the child was apparently well in a few days.

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REMARKABLE CONTENTS OF A DERMOID CYST.—At the New York Obstetrical Society, May 5th, Dr. Mundè presented a switch of hair, five feet long, which he had removed from a dermoid cyst of a woman, 41 years of age. There was a dermoid

tumor of each ovary, the right one being as large as a pregnant uterus of six months, and containing this switch of hair, the other a small ball of hair and several teeth. This large switch sprang from a small nipple-shaped protuberance at the upper portion of the sac, which was unilocular. At its root the switch was not more than an inch in diameter, gradually enlarging to a rope of matted hair as thick as the forearm. Dr. Mundé thought that probably very few cases of such enormous cranial development in a dermoid cyst are on record.—*N. Y. Journal Obstetrics.*

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VOMITING OF PREGNANCY AND HYSTERIA.—Kaltenbach holds that the clinical history of the "cures" of cases of uncontrollable vomiting of pregnancy indicate that the disease is essentially due to hysteria. Pregnancy involves physiological and psychological conditions favorable to the development of hysterical symptoms in a modified form. Hyperemesis is often cured by a process akin to suggestion, like ordinary hysteria. "Doing something," dilatation of the os, massage, etc., often succeeds if the practitioner gains the patient's confidence, and hosts of drugs have answered, apparently, under the same conditions. On the other hand, all of these vaunted medicines and operations have failed when applied by physicians who possibly did not possess as much tact as knowledge. Hyperemesis may suddenly cease if the patient be alarmed, as in a case of the author, where the patient was reduced to a skeleton; a day being fixed for the induction of labor, her friends frightened her by saying that she could not survive such an operation. The vomiting ceased. The same sudden arrest of hyperemesis was observed by Cazeaux in a young wife whose husband was seized with symptoms of strangulated hernia. In a third case, the vomiting ceased on the outbreak of an acute exanthematous fever. Kaltenbach describes a bad case where the patient, aged twenty-one, made an unhappy marriage, and was unkindly treated by her husband. Very severe vomiting set in during



her first pregnancy, and she was sent into a hospital. It was suggested to her that she had lumps of unwholesome material in her stomach, and that their removal would cure her. Some milk was given to her, ceremoniously, and shortly after the stomach was washed out. Its contents bore no indications of either over-acidity or any abnormal ferment. The patient was then informed that all was right, and that the vomiting would not return. It ceased accordingly, and she was safely delivered at term. In short, Kaltenbach urges that hyperemesis gravidarum should be treated as a purely hysterical complaint. Prompt treatment is indeed necessary, for, as in hysterical vomiting of non-pregnant women, the patient may, if at first neglected, die of syncope or nervous exhaustion, even when the vomiting has been stopped. But isolation from domestic cares and imprudent friends, with appropriate moral treatment, should be enforced before so extreme a step as artificial abortion is undertaken.—*British Medical and Surgical Journal.*

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**A RELIABLE PURGATIVE ENEMA.**—The following enema has proved so reliable and satisfactory in my hands, that I feel it is worthy of a brief note:

R. Sulphate of magnesia, 2 ounces.

Glycerin, 2 ounces.

Oil of turpentine,  $\frac{1}{2}$  ounce.

Water, 2 ounces.

M. Label, "To be used as an enema."

To move the bowels after abdominal section, or after plastic operations on the female pelvic organs, it has been in constant use for many months. When used alone it has moved the bowels, as a rule, promptly; and has been equally effective when given as an adjuvant to some cathartic taken by the mouth.

Prior to the employment of this formula, I had used the simple enemata of glycerin, and of glycerin and turpentine, which are distinctly inferior to the one above recommended.

The combined action of Epsom salts, turpentine, and glycerin is very effectual, not only in evacuating the rectum, but also in

getting rid of flatus, which is the cause of much of the pain present after abdominal section.

I have had the opportunity, upon two occasions, of testing the activity of this enema in cases of threatened obstruction of the bowels, following operation. Other measures failing—including purgatives and large and small enemata—I have introduced a long, soft tube up the rectum, and given this enema into the descending colon, with the happiest results.

Now that the use of opium has been banished from the after treatment of cases of abdominal section, this enema has, in my hands, become the great anodyne.

When given through the rectal tube, its employment promises much in cases of partial obstruction of the bowels, also in obstruction due to paralysis of the bowel.

The enema is best given through a hard-rubber piston syringe.—*Charles P. Noble, M. D., in Medical News.*

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TREATMENT OF PNEUMONIA WITH LARGE DOSES OF DIGITALIS.—Dr. Petresco, of Bucharest, makes an infusion of sixty grains of powdered digitalis leaves to six ounces of water, a little syrup of orange being added to sweeten it. A tablespoonful of this mixture is given every half hour. In spite of the largeness of the dose, he says he has never met with a case of poisoning, and maintains that these doses are therapeutic, and not toxic. The best results are obtained in fibrous or croupous pneumonia. The author states that if used in the way he describes, digitalis will frequently cut short an attack of true croupous pneumonia. In from twenty-four to forty-eight hours after taking the drug, a certain fall of temperature occurred, from 104° F. to 98° F., this being accompanied by a decrease in the frequency of the pulse and respiration. The digestive tract was little affected. The most marked changes were noticed in the pulse, which became slow, full, and of high tension. The conclusions to which Petresco has come are as follows :

1. When given in therapeutic doses, digitalis has a direct antiphlogistic action.
2. The dose may be raised as high as from

60 to 120 grains of the leaves given as an infusion within twenty-four hours. 3. This treatment may be continued for from two to four days, if the severity of the case requires it. 4. When improvement takes place in the circulation and respiration, this is speedily followed by a disappearance of all local signs and symptoms. 5. The success of this treatment is confirmed by the statistics. In an elaborate table of statistics, Professor Petresco shows the superiority of digitalis over the other methods. Thus the highest mortality in pneumonia (34.5 per cent.) occurred when bleeding was practiced, and the lowest (three per cent.) when tonics, alcohol, etc., were employed. When digitalis, however, was administered the mortality sank as low as 2.06 per cent. 6. From an experience of a very great number of cases, both of his own and other medical men, he maintains the doses, as given above, are perfectly harmless. 7. After a comparison of the various methods of treating pneumonia, Petresco affirms that the expectant plan is not only without reasonable foundation, but even dangerous. His experience has demonstrated that an attack of pneumonia may be aborted if the treatment is commenced at the earliest stages of this disease.—*Therapeutische Monatshefte*.

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LIFE INSURANCE AND SYPHILITIC "RISKS."—Mr. Jonathan Hutchinson has published a paper in the *London Practitioner* on the "Modern Treatment of Syphilis," in the course of which he considers some of the more important relations of syphilis and life insurance. He states that he has recently been requested by a life insurance company to formulate a code of rules for the guidance of its examiners when considering the acceptance or rejection of applicants for insurance who have had syphilis. His advice on this subject was for the most part favorable to the applicants; with this exception, however, that he would decline those persons who, at the time of their presentation, shall be undergoing the active development of secondary symptoms. These applicants, he advises, should be told to wait until these symptoms had disappeared. He based this counsel on the

fact that it is always desirable to know how well or how ill the syphilitic patient sustains the specific treatment proper to the second stage of the disease, and also how willing and attentive he may be to follow out the directions of his physician. Mr. Hutchinson holds that an insurance company might make a profitable business out of syphilitic risks accepted in the early stage of the disease and taken at the ordinary rates, for he has found that the threatened life is often a long one. In his experience such syphilitic persons appear quite as likely to attain to length of days as others who have not been syphilitic. In the cases of those who present themselves free from symptoms, but who have the history of a former attack, the advice is that they be not refused, provided that they have not definitely become the subjects of the tertiary lesions of the disease, or have not, owing to idiosyncrasy or inadequate treatment, had a prolonged siege of secondary symptoms. But even among these there are not a few who would be regarded by Mr. Hutchinson as eligible risks at ordinary rates.—*Jour. Am. Med. Association.*

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**DONOVAN'S SOLUTION IN GLEET.**—The solution of the iodide of arsenic and mercury is said to be of material service in the treatment of gleet. A correspondent of the *Medical Record* feels that he is justified in calling this remedy almost a specific for gleet, so uniform has been his success with it. It should be given for this purpose, in doses of ten minims, three times daily.

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**COLD IN THE HEAD.**—For this, while in the acute congestive stage, there is no better remedy than gelsemium. One good large dose, say ten minims of the fluid extract, taken before going to bed, is usually sufficient to dispose of this troublesome and uncomfortable affection.—*Medical Compend.*

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The JOURNAL recently had a visit from Dr. J. B. S. Holmes, of Rome. The doctor has since taken a trip to New York for a look into the clinics on his special line, diseases of women. His elegant Sanitarium at Rome will be open from this date.

## Book Reviews.

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TRANSACTIONS OF THE SOUTHERN SURGICAL AND GYNECOLOGICAL ASSOCIATION. Vol. III. Published by the Association.

It contains some valuable papers, presenting the advance thought of the day pertaining to surgery and gynecology, deserving careful perusal and study. The character of the articles is such that a much older society might consider itself fortunate to receive such contributions. Although the Southern Surgical and Gynecological Association has but passed its third mile-stone, it numbers as active workers and contributors some of the best talent this country affords.

To enter into the discussion of the merits of the articles presented would consume more space than is allotted to this review.

The address of the president regarding the health of the American girl as imperiled by the social conditions of the day should be read by every physician, and when opportunity affords impress on the mother and daughter the signals of danger and advice contained in this article. If such a paper could be placed in every home and its teachings heeded, a vast amount of suffering and disease would be avoided, and its influence soon be made manifest in improving the physical, mental and moral condition of the mothers of future generations. In the list of contributors to this volume we find such names as Engleman, Kelley, Price, Reamy, McMurty, Roberts and others, which are a sufficient guarantee of the worth of this volume. The papers, with their discussions, form a book well worthy a place in a thinking physician's library.

R. R. K.

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STANDARD ENGLISH DICTIONARY. We have received some advance pages of this great work, which is to be issued by Funk & Wagnalls, 18 and 20 Astor Place, New York, and from what we can judge, at present, we should say that when finish-

ed it will be the completest and most reliable single volume dictionary in the language.

Among the eminent scholars who are in charge of the different departments of the work, may be mentioned, Professor Shaler of Harvard, Ex-Minister E. J. Phelps of Yale, Professor March of Lafayette College, President William R. Harper of the University of Chicago, Professor Simon Newcomb of Johns-Hopkins, Professor Max Muller, Professor Huxley, etc.

These editors are among the best known of American and English scholars ; each is an acknowledged authority in his particular sphere of learning. The Dictionary, from beginning to end, will be the work of scholars, and of experts in the different branches of the arts and sciences and in the different trades. Without reflecting unfavorably upon the work of others, we may be permitted to say that no dictionary of any language has had engaged upon it so many representative scholars.

Among the

#### DISTINGUISHING CHARACTERISTICS

of the Dictionary are the following ;

1. The etymology is placed *after* the definition.
2. In the definition of a word the *most common meaning* is given *first* ; that is, preference is given to the "order of usage" over the historical order, usually followed in dictionary making. The aim is to remove everything that stands between the vocabulary word and the meaning that will be more generally sought after by the average reader.
3. The *scientific alphabet*, which has been prepared and recommended by the American Philological Association, and adopted by the American Spelling Reform Association, is *used in giving the pronunciation of words*. This department is under the direction of Professor Francis A. March, President of the American Spelling Reform Association, and who is recognized in Europe and America as one of the most eminent of living philologists.
4. *Disputed pronunciations and spellings* are referred, under the direction of Professor March, to a committee of fifty. This committee is composed of philologists in leading American, English, Canadian, Australian and East Indian Universities, and represent-

ative professional writers and speakers in English. By a simple system the form preferred by each committeeman will be indicated in the Preface to the Dictionary. The preference of this committee is advisory to Dr. March ; it is not mandatory.

5. If a vocabulary word is variously pronounced, we give first the pronunciation we prefer, then the pronunciation preferred by each of the other dictionaries.

6. A committee of five representative scholars will pass upon new words before they are admitted into the Dictionary.

7. The illustrative quotations are "*located*," that is, the volume and page where each is to be found are given.

8. Strictly obsolete and dialectic words, and such foreign words as are used only rarely in English literature, are placed in a Glossary in the Appendix, thus saving space in the Dictionary proper for tens of thousands of important living words that heretofore have been omitted from single volume dictionaries.

9. The different parts of each science are so treated, that the student can easily trace the definition of all its branches, and have before him the full meaning of the science ; that is while the terms belonging to each branch or subordinate branch of a science are defined in their proper vocabulary places, the references to their superior and subordinate branches are so given that the definition of the science as a whole can easily be traced and collected, and when so collected will be found by the student to be a full and harmonious exposition of the entire science.

10. The church terms peculiar to the Roman Catholic Church, and to each of the Protestant denominations, and to other churches and religious organizations, are edited by a representative of the church or organization to which these words belong.

11. *Antonyms*, as well as synonyms, are given where this is thought important ; examples showing the proper use of *prepositions* are freely supplied in connection with different vocabulary words.

12. In the vocabulary, only proper names, or proper terms derived from them, are printed with initial capital letters, thus enabling any one to determine at a glance whether or not a word is to be written with an initial capital or small letter.

13. The work will contain *all* the words to be found in the latest Worcester, Webster, Stormouth and Johnson, and *nearly 70,000 more*.

The present seems to be a day of gigantic enterprises in dictionary-making, and we await with interest the appearance of this last.

# THE ATLANTA AND MEDICAL SURGICAL JOURNAL.

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## TO CONTRIBUTORS.

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## Original Communications.

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### CATARRHAL FEVER.

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By V. D. LOCKHART, M. D., HOMER, GA.

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This disease embraces two stages, the dry and the moist, and the indications for treatment are somewhat different in each.

To relieve the fever and coryza of the first stage antifebrin is a good remedy. It may be combined with quinine.

R. Antifebrin, gr. viij—x.

Quinine, gr. v.

M. This will generally insure rest and a moist skin.

A purgative,

R. Hydrarg. chlor. mitis., gr. v.

Ipecac, gr. j.

Rhei pulv., gr. viij.

M. One dose, to be followed by a dose of Epsom salts or castor oil if needed.



Order a bowl of hot water, add a few drops oil turpentine; let the patient inhale the vapor, a shawl or blanket thrown over the head to confine the steam. This often affords much relief. If the throat be sore apply turpentine to the fauces with a swab.

After the purgative has acted give,

R. Tinct. aconiti rad., 3j.  
 Vini antimonii, 3ijss.  
 Spt. ether. nitros., 3vj.  
 Liquor ammon. acetatis, q. s. ad. 3jv.

One-half teaspoon- to teaspoonful every two. to four hours as indicated. Children four or five years of age twenty drops. Opiates are not good for this stage, but if there is much restlessness a dose of Dover's powder may be given. Antikamnia is better. Mustard should be used as a counter-irritant. One part of ground mustard to two of flour. It should be applied frequently during the disease, and when the mustard is not on, a poultice of wheat bran or cloths wrung out of warm water, and over it a layer of oiled silk. Quinine in moderate doses three times a day. The temperature of the room should be kept pleasant. Under this treatment the cough will become loose, fever will subside and dyspnœa and soreness of the chest cease in a day or two. Then give,

R. Syrup scillæ,  
 Syrup senagæ,  
 Syrup tolut.,  
 Tinct. opii. camphorat., aa 5j.  
 Ammonii chlorid., 3ij.

M. Sig.—Teaspoonful every three or four hours. Digitalis comes in well and it may be added to the syrup as indicated.

In small children prompt and efficient measures are often needed to relieve the dyspnœa and other threatening symptoms. Give fluid extract ipecac in doses sufficient to insure free emesis. This may be necessary at intervals for several days, but it must not be given so as to keep the child nauseated, as this interferes with the measures of support, which are important, especially if the child have pertussis. In this disease we must support the strength by using stimulants and rich, nourishing food, and they

are indicated early. Besides the usual treatment indicated above the following is a good prescription for *whooping-cough* :

℞. Ext. cannabis indicæ, gr. xv.  
Ext. belladonnæ, gr. viij.  
Alcohol,  
Glycerin, ad. ʒjss.

M. Sig.—Four or five drops to a child one year old; one of two years old, five to a eight drops three or four times a day.

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## ONE HUNDRED CONSECUTIVE CASES OF SKIN DISEASE.

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### X.

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By M. B. HUTCHINS, M. D.,  
Lecturer on Diseases of the Skin, Atlanta Medical College,  
Atlanta, Ga.

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#### ALOPECIA AREATA.

Of this disease there was one case, that of a young physician, age twenty-nine. Hair began coming out, in irregular patches, about a month previous to consultation. Hairs still present in the patches loose, and here and there the hairs had that broken, peg shape something like an exclamation point under the microscope, so characteristic of the hairs usually seen at the edge of a patch in this disease. The disease appeared worse after two weeks use of,

℞. Hydrag. bichlor., gr. xvi,  
Sp. vin. rect.,  
Aquæ, aa ʒii,

M.

applied to the scalp with friction. As many of these cases recover spontaneously, I asked the doctor to leave off all treatment,

and see what the result would be. He did so. In exactly three weeks he reported full regrowth of the hair.

#### PRURITUS ANI.

One case of this trouble ; robust young man of twenty-nine. Present more or less for ten years. Never had hemorrhoids, and anus appeared normal upon inspection, save a half pea-sized papular growth of pale color. This was immediately cut off with scissors. Patient believed the troublesome itching to be due to irritation of the stiff hairs around the anus and to the secretion—moisture. Was given,

R. *Sapōnis viridis*, ʒii,  
Sp. vin. rect., ʒi,

M.

to use in washing the part. After washing, and three times a day was to use—

R. Menthol., gr. x.  
Picis liq., ʒii.  
Ether. sulph.,  
Alcohol, aa ʒi.

M.

I forgot to state that the general health was good and the bowels acted regularly.

The applications relieved the itching, but, in about eight days, produced some irritation. This was subdued by the use of,

R. Zinc. ox. pulv., ʒij.  
Bismuth subnit.,  
Amyli., aa ʒi.

M. Sig.—Apply on cotton during the day. To continue application of prescription number two in case the itching tended to recur.

At the end of another week the patient became constipated and there was slight hemorrhoidal congestion. The further history of this case is not known.

The case of a woman, aged thirty-one, who had slight varicose veins of the leg, chronic diarrhœa, and a history of general bad health was diagnosed, primarily, *purpura hemorrhagica*. The escape of blood from the vessels of the affected leg was probably

due to the bad circulation. (Purpura is really a symptom, and not a disease, and may be due to various causes.) On left leg, lower part, there were numerous "nail-head" sized, purplish points due to extravasated blood, and within this affected area a small irregular ulcer, in the center of which could be seen a minute bluish point, suggesting a ruptured venule. General tonic treatment was instituted, with iron, quinine and strychnine. Locally, chiefly for the benefit of the ulcer,

R. Ichthyol.,  
Glycerine, aa 3ii,  
Aquæ, ad. 3vi,

M.

was ordered used often enough to keep the surface wet. Later it was found necessary to protect the ulcer, partially, with corn-starch. Absorption of extravasation took place rapidly. Besides giving a history of numerous diseases—the patient later gave information which suggested the possibility of syphilitic infection at some distant date. She was given small doses of bichloride of mercury in combination with bismuth and nux vomica. This improved the diarrhœal condition. Ungt. hg. 1 with ungt. zn. ox. 2 did not help the ulcer, as it should have, had syphilis been an element in its production. Under,

R. Iodoformis, 3ii,  
Amyli., 3vi,

M.

the ulcer nearly healed and the cure was completed with the "ichthyol lotion."

#### EPIDERMIC HYPERTROPHY, ETC.

Patient, man of forty-one. Condition present about ten months. The carmine border of the lower lip was the seat of this peculiar condition. The epidermic layers of the skin here were markedly thickened, the thickened part loosely attached to skin beneath and the margin sharply limited at the mucous membrane within. The color was the peculiar white of water-soaked, new rubber. There was one small scar. (He stated he had had "fever blisters.") A few slightly enlarged (skin) papillæ were visible in the diseased surface.

Sometimes burned the lip with very hot coffee, which he was in the habit of drinking. General health was good, but he had taken a dose of Simmons' liver regulator every night for five years to keep his bowels "open."

R. Sp. vin. rect., ʒi,  
Acid sal., q. s. ad. solutionem saturatum,

M.

was used at first, with partial success in removing the hypertrophy, but finally ceased to have any effect. *Caustic potash* was then cautiously applied and the thus softened epidermis scraped away with the curette. Finally,

R. Acid. salicyl., gr. x,  
Collodii, ʒss,

M.

was used, but not regularly. This, however, finally removed the disease. Just six months later there was a slight return of the disease, but this disappeared, under slightly stronger "salicylic-collodion" application, in less than two weeks. When first treated, the patient was ordered to leave off the "liver medicine," and was given the "cascara and nux mixture." He reported that its use produced a cure of his constipation.

#### DERMATITIS VENENATA.

This was the case of a young lady of twenty. Symptoms were those usually seen as result of poisoning with "poison oak" or "ivy." Face, nose and right ear inflamed, discharging and forming sero-crusts, just as in an acute eczema, or a dermatitis from any local irritant. On face the following:

R. Acid. sal., gr. xxx.  
Zn. ox., ʒii.  
Ungt. simp., ʒii.

M. Sig.—Keep well applied. In and about ear the following powder was used:

R. Zn. ox., ʒi.  
Bismuth. subnit., ʒii.  
Amyli., ʒi.

M. This treatment caused quite rapid improvement. The

eruption occurred on the shoulders, in a few days, and the following lotion was ordered:

R. Calamin. prep., ʒi.

Zn. ox. pulv., ʒii.

Aquæ calcis, ʒiii.

Aquæ, ad. ʒiv.

M. Sig.—Apply to affected surfaces. The patient reported later that she was advised to use “nightshade and cream,” and that it “cured” her. It is possible that belladonna may have something of an antidotal effect upon the poison.

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This ends the report of the hundred cases, the notes of which were made a year ago.

In conclusion, I wish to thank the members of the profession, by whom the majority of these cases were referred to me.

1 ½ Edgewood Ave.

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## SUPRAPUBIC CYSTOTOMY.\*

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By R. W. STEWART, M. D., PITTSBURG, PA.

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The following cases operated on by myself during the present year, and given in the order of their occurrence, will serve to show some of the conditions for which this operation is indicated, and also serve as a basis for further remarks on the operation:

CASE I.—This patient was under the care of Dr. Grube, who has kindly furnished me with the following notes of the case:

February 10th, 1891. J. O., age 32, furnaceman. Patient says that about six months ago he first noticed difficulty in urination, with pain in bladder and penis. This gradually passed into chronic cystitis, accompanied by pain in legs and partial paraplegia. He was treated for cystitis at Mercy Hospital. The bladder is extremely irritable, and holds scarcely an ounce, and

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\* Read before Allegheny County Medical Society, August 18, 1891.

as the slightest distension causes intense pain, it is impossible for him to sleep longer than half an hour at a time ; consequently he is greatly reduced in strength. The stomach is irritable, and digestion impaired ; patient living almost entirely on milk. The prostate gland is slightly enlarged, and is nodular, leading to the suspicion that it is tubercular. Patient has a brother who has pulmonary tuberculosis, and he himself has had a cough for several years, though his lungs are not perceptibly tubercular. Urine contains large quantities of muco-pus. Microscope shows pus cells, caseous flakes and débris. As patient was under Dr. Stewart's care at Mercy Hospital, I have asked him to see patient, and we have decided upon suprapubic cystotomy.

February 14th. Dr. Stewart operated as above, assisted by Drs. Ward, Patterson, Emmerling and myself. As the bladder would not bear distension by fluid, the fundus was pushed up into wound by point of sound. A papillomatous growth was removed from near entrance of left ureter—about a teaspoonful of scrapings in all. Wound closed and bladder drained by single large drainage tube ; directed daily washing out of bladder with boro-salicylic acid solution.

February 20th. Patient has been given great relief from irritability of bladder, and is grateful accordingly. Urine still muco-purulent ; general condition, bad.

March 10th. Wound has healed nicely around drainage tube, and patient manages drainage and washing out of the bladder himself.

April 1st. No improvement in character of urine, and patient losing ground steadily. There are occasional discharges of caseous-looking pus from urethra, which evidently comes from the prostate. Tubercles have made their appearance in the cicatricial tissue about the drainage tube.

The further progress of this case was a gradual decline, until he died about the middle of May.

CASE II.—Daniel R., age 54. About eight years ago he had several attacks apparently of renal colic, occurring at intervals of two months. After this there was a period of quiescence until about eighteen months ago, when he complained of

frequency in passing water, the termination of the act being associated with pain, which was referred to the end of the penis. Exertion of any sort aggravated the trouble, while on the contrary, rest in the recumbent position diminished it. So frequent had become the calls to urinate, and so difficult to restrain the desire, that it was necessary to wear a urinal. For about a year the patient was unable to pursue his vocation of machinist. He was referred to me for treatment by Dr. Ward.

Owing to the extreme sensitiveness of the patient and the irritability of the bladder, an examination without the aid of an anæsthetic was a matter of considerable difficulty, and required the utmost tact and delicacy. A diagnosis of vesical calculus was made, and the patient sent to Mercy Hospital for operation. Accordingly, on March 15th the patient being anæsthetized, a rectal bag was inserted and distended with eight ounces of water. The suprapubic operation was then performed, and three calculi lying side by side were removed. A drainage tube was inserted in the bladder and the wound partially closed with three silver sutures. A loose gauze dressing was applied over all.

The condition of the patient after operation was satisfactory, and was devoid of constitutional disturbance. He left the hospital on the seventeenth day following the operation. A fistulous opening still communicated with the bladder, which was somewhat slow in healing, but eventually it closed, and at this date patient is in good health, has full control of his urine and is free from pain.

CASE III.—Louis M., age 34, a butcher by occupation. On the evening of May 28th, he stepped on a coal-hole, the lid of which turned and he fell, the edge of the lid striking him on the perineum. He was able to walk a short distance, and then took a carriage home. On the following morning he was suffering from retention of urine, and Dr. Speer was called to see him. With a soft catheter he withdrew a quantity of bloody urine. On the evening of the same day I was called in consultation, the doctor being unable to withdraw his urine. At that time the bladder was distended, perineum tender, swollen, and much discolored, the discoloration extending to the scrotum. A diagnosis



of rupture of the urethra at the triangular ligament was made, and with the assistance of Drs. Speer, Christler, and McKibben, the patient being anæsthetized, I opened the perineum freely in several places, through which a small quantity of bloody urine escaped. A complete rupture of the urethra was discovered. Owing to the extravasation, the tissues were so altered in appearance that it was impossible to distinguish the vesical end of the torn urethra; after a patient attempt I abandoned the search for it, and ordered his removal to Mercy Hospital. He did not enter the hospital on the following day, and as he was still suffering from retention it was necessary to aspirate his bladder in the morning and evening. On the following morning he entered the hospital, and I operated on him again. At this time the patient's temperature was 103° F., and his general condition was bad. Being again unable to find the vesical end of the urethra, I opened the distended bladder above the pubes, the incision in the bladder being just sufficient to admit a steel sound, with which I performed retrograde catheterism. The sound, after passing from within outwards through the prostatic urethra, was made to project through the perineal opening. While in this situation a stout rubber tube was fitted on the projecting conical extremity of the sound, which, together with the tube, was withdrawn into the bladder, and the sound disengaged from the tube. The sound was then passed from before backwards through the pendulous urethra, the extremity again presenting through the perineal opening. On this was fitted the end of the rubber tube which projected from the perineal opening, and the sound carrying with it the tube was withdrawn. By this manœuvre a tube was inserted in the whole length of the urethra, one end being in the bladder and the other projecting from the external meatus, the central portion bridging over the torn ends of the urethra, which were separated by an interval of about three-quarters of an inch. Displacement of the tube was prevented by pinning it to the prepuce. The patient's condition improved at once; his temperature was normal on the third day. The urine drained through the tube. A slight leakage escaped through suprapubic opening. On the eighth day the tube was removed, and the

patient left the hospital on the twelfth day, since which time no urine has passed by suprapubic opening. A No. 26 French sound has been passed at intervals since that date. At present the sound is passed once every two weeks to prevent the formation of a stricture at site of injury, and except for this inconvenience the patient is as well as he ever was.

CASE IV.—A. M. W., age 21. Ten years ago this patient was suddenly attacked with a desire to urinate frequently, which he attributed to holding his urine too long. This condition has persisted without intermission during the past ten years, passing water every twenty to forty minutes, night and day, the act being associated with violent tenesmus, and, at times, excruciating pain. The constant straining has produced a marked prolapse of the rectum, which protrudes during the act to the extent of about five inches.

Three years after the onset of this attack he became subject to epileptic seizures, which would occur about once a month, and in some manner seemed to be associated with an exacerbation of his vesical trouble. I may anticipate by saying that since the latter has been relieved the convulsions have ceased.

During the ten years he has suffered he has tried various forms of treatment in hospitals and out of them, under regulars and irregulars, besides his attempts at self-cure with the aid of patent medicines, all of which, to use his own language, did him no good, and he was waiting to die. Finally Dr. Buchanan sent him to Mercy Hospital, and he was transferred to me. The case was and still is something of a puzzle. The sound failed to shed any light on the subject, the cystoscope was also used, but nothing abnormal could be detected; external perineal urethrotomy performed, and a digital examination of the interior of the bladder was made by Dr. Buchanan and myself, but nothing abnormal, further than a dilatation of the opening of the right ureter could be detected. Into this opening I readily inserted the beak of Thompson's seacher, which passed, without obstruction, along the ureter until it must have reached the pelvis of the kidney. In this situation the searcher could be readily turned in any direction, showing that the ureter was much dilated. While the

searcher was in this situation the descent of the liver in inspiration could be readily felt pressing against the extremity of the instrument. The ureter contained about an ounce of apparently healthy urine, which escaped along the hollow instrument. A drainage tube was inserted in the perineal opening, and the bladder drained by this means for ten days. During this period the patient had comparative comfort, and for the first time in ten years he was able to sleep a few hours at a time. After the tube was withdrawn on the tenth day, the perineal opening closed, and the patient relapsed into his previous miserable condition.

The results of all these examinations showed that we were no nearer the solution of the cause of this trouble. Whether the dilated ureter was the cause, or the result of the frequent urination, we were unable to determine; one thing, however, was apparent, that drainage of the bladder relieved the symptoms, and I therefore decided to establish permanent drainage.

In this operation I was again assisted by Dr. Buchanan. A specially contrived sound, having a greater curve than the ordinary sound, and a tip on it over which a tube could be readily fitted, was used. The extremity of the instrument could be felt just above the pubes, an incision was made over it, and the instrument presented itself in the wound. A tube was inserted over the tip of the instrument, which was withdrawn, leaving the tube in the bladder, and a permanent drainage was now established. The patient, in a short time, was able to manage the tube himself, taking it out twice daily, and washing the bladder with a weak bi-chloride solution, the free extremity of the tube fitting into a urinal by day, and at night connected with a long tube which carries the urine to a vessel placed at the bedside. When last seen he had gained in flesh, could sleep without interruption, and for the first time in his life he was making arrangements to earn a living for himself.

The operation of suprapubic cystotomy has, within the past few years, attracted considerable attention, and is now looked on with more favor than at any previous period. Some have gone so far as to condemn entirely the perineal route to the bladder, and assert that the suprapubic route should be used exclusively ;

but that this is going too far will be evident to any one who will give the subject a little attention. For temporary drainage and for digital exploration, the perineal method of opening the bladder is undoubtedly the simplest and the safest. On the other hand, the suprapubic method is, in the majority of cases, to be preferred for the removal of calculi too large to be crushed ; also for the removal of tumors, with the possible exception of prostatic growths, and for the establishment of permanent drainage. This operation has been hedged around with so many precautions and imaginary dangers that what is really a very simple operation appears to the uninitiated to be one of great magnitude.

Elaborate dissections have been made to show the relationship of the vesico-parietal peritoneal reflection to the operation, and the benefits of rectal and vesical distension have been urged. The dangers of urinary extravasation and hæmorrhage have been pointed out, and the advantages of Trendelenberg's position dilated upon. Regarding the much-talked-of peritoneum : In none of the cases that I have recorded was it seen during the operation, and in only one of them was a rectal bag used. While vesical distension was resorted to in none, though present as an accidental occurrence in case three, the advantages of both of these have, in my opinion, been more than counterbalanced by the risks incurred from over-distension in their use. A longitudinal incision was used, keeping close to the upper border of the symphysis pubis, and the bladder opened on the tip of a well-curved sound, the finger being kept at the same time in the upper border of the wound to prevent displacement downwards of the peritoneum and intestines. A pair of forceps was next insinuated alongside the sound, into the bladder, and expanded so as to tear the vesical opening to the extent desired. Hæmorrhage was not troublesome in any case. No attempt was made to suture the vesical wound, nor would I recommend that it be attempted, unless the opening was very large. In three of the cases the abdominal wound was partially closed with silver sutures ; but in each of these cases the wound reopened on removal of the sutures, so that in the future I will dispense with their use. I would recommend, however, that the incision, both

in the abdominal wall and bladder, be limited to the smallest extent consistent with the requirements for operating within the bladder.

No constitutional disturbance was produced by the operation in any case, no extravasation of urine occurred, and the after-treatment consisted of frequent renewal of the dressings and washing out of the bladder with a mild antiseptic solution.

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**EHRlich's TEST IN TYPHOID FEVER.**—This test, which has been known for a number of years, has till recently been regarded by many rather as a medical curiosity than as of diagnostic value. Dr. C. E. Simon, of the Johns Hopkins Hospital, has recently shown that by carefully following the precise directions for its use valuable information may be derived. The test consists of two solutions : 1. A saturated solution of sulphanilic acid in five per cent. hydrochloric acid. 2. A five per cent solution of sodium nitrate. These are to be mixed, just before use, in the proportion of 40 c.c. of (1) to 1 c.c. of (2). If this mixture be added to urine from a case of typhoid fever, the further addition of ammonia will produce a play of colors varying from an eosine rose to a deep garnet red. The best method of applying the test is to take a few centimetres of urine in a test-tube, adding an equal quantity of the sulphanilic acid mixture, and shake thoroughly ; 1 c.c. of ammonia is then run carefully down the side of the tube. At the junction of the two liquids there will be observed a ring of the characteristic color, which is produced in scarcely any other disease than typhoid fever. Dr. Simon's conclusions may be thus summarized : 1. The reaction may be obtained in typhoid fever from the fifth to the twenty-second day of the disease. 2. Its absence from the fifth to the ninth day indicates a very mild attack, save in children, although this rule is not absolute one. 3. As it occurs previous to the appearance of the rash, it is a very useful aid in the diagnosis of typhoid fever.—*Therapeutic Gazette*.

## Society Reports.

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### ALLEGHENY COUNTY MEDICAL SOCIETY.

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SCIENTIFIC MEETING, AUGUST 18, 1891.

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T. D. DAVIS, M. D., President, in the chair.

A paper on "Suprapubic Cystotomy" was read by Dr. W. R. Stewart. See page 519.

DR. BUCHANAN: I am very well acquainted with the history of the fourth case reported by Dr. Stewart, and I think the doctor deserves the greatest credit for the way in which he followed up the treatment. The case was a very mysterious one, and yet remains so. There was no obstruction of the urethra. There was no active cystitis. There was no disease in the kidney, or in the pelvis of the kidney, as far as could be discovered. There was nothing to give rise to the dilatation of the ureter, the enlarged outlet of which could be felt very plainly with the finger through the perineal incision and demonstrated with the sound, except the constant contraction of the bladder. The opening of the bladder for permanent drainage above the pubis was an entirely arbitrary matter, not based on anything except the fact that during the time at which the bladder was open below, the patient was relieved from pain. For this reason I think Dr. Stewart deserves the more credit for following up that hint and doing this operation without any other indication; an operation which has certainly proved very successful. The man was in a wretched condition; the contractions of the bladder were so painful as to make him cry out; he could not stand still when passing his water, and there was very extensive protrusion of the rectum.

DR. MACFARLANE: I have nothing to say except to compli-

ment the doctor upon the manner of presenting his cases. There is one feature about the one case in which I cannot help but admire the manner in which he treated it. The case is the one in which he had rupture of the urethra. Now anybody who has ever attempted to do anything with rupture of the urethra knows the difficulty connected with it. I have on two occasions seen men of ample experience spend two hours or more before being able to unite the urethra; on another occasion an hour and a half was spent with lack of success, the work being left to be completed at a later time, the man being, in the interval, in a precarious condition. Now, the doctor's method of treating that, I think, deserves widespread circulation, for it certainly acted very well indeed, and affords a very happy escape from the great difficulty connected with a case of rupture of the urethra.

DR. McKENNAN: I have a specimen which may be of interest to the members of the society. It was sent to me by Dr. Ray Grayson, of Washington, Pa. It is a congenital malformation of the rectum. The rectum ends at the base of the bladder. It is interesting on account of the fact that we very seldom get a *post-mortem* in cases of this kind, and it represents a type of cases not at all uncommon. An examination of the rectum here discloses the fact that there is peritoneum connecting the rectum with the bladder. The rectum enters directly at the base. Some times the rectum enters the bladder at the vertex. After an examination is made, it will be seen that the peritoneum surrounds the entire lower part of the rectum running from the bladder directly to the rectum and surrounding it. This case represents one of a type of these cases of congenital malformation of the rectum which vary from occlusion of the anus to complete absence of the lower bowel. It is said that congenital malformations of the rectum and anus occur about once in every 5,000 deliveries, although some observers state that in statistics of 66,000 cases of delivery, congenital malformation of the rectum and anus occurred only three times. Other observers, however, state that congenital malformations do occur as often as one in every 5,000. To my knowledge, quite a number of cases have occurred around here. It is obvious from the mal-

formation here that operative procedures were hazardous. An attempt in this case was made to reach the rectum but failed. The diagnosis was properly made of entrance of the rectum into the bladder by the appearance of the fæces in the urine. The operation, I believe, was made on the patient on the 17th day, and the patient lived until the 26th day.

DR. STEVENSON: I have seen three cases of imperforate anus; in one of the cases the rectum terminated in the bladder. In that case there was an attempt made to reach the rectum, but it failed and the child died. In two other cases I have seen the rectum was reached, and the method pursued was passing up a hypodermic needle and withdrawing the fæces and cutting up alongside of the needle, and the rectum was reached and drawn down and the opening stitched. These children both recovered, and had no trouble with their bowels.

DR. STEWART: It seems to me that in this case a suprapubic cystotomy would have been proper, and would have given relief.

DR. BUCHANAN: I think a very much better way would have been to open the sigmoid flexure of the colon; that can always be reached. It would be very much better to drain the fæces out by an abdominal fistula than through the bladder.

DR. MCKENNAN: I find that operations in cases of this kind have never been successful. Operations have been done, some operators opening the perineum, cutting into the bladder and thence making a cut clear through the opening of the rectum into the bladder, making thus a large wound into the perineum. But this method of procedure either produces peritonitis or it causes a fistulous opening in the perineum, which greatly contracts. The only operation which can be done with safety is that suggested by Dr. Buchanan, and that is the operation of colotomy. I find that in malformations of the anus and rectum, that in which the rectum enters the bladder occurs in about forty per cent. of all malformations.

#### GENERAL DISCUSSION ON SURGICAL JOINTS.

DR. MURDOCH: I am not exactly clear as to what is meant by



surgical joints. I suppose it may be joints liable to disease or injury, or that might come under the care of the surgeon, but in that case it would properly include every joint in the body, for there is no joint that might not require surgical treatment; therefore I do not like the term wholly. I suppose, however, reference is intended to be made to those joints which more frequently come under the care of the surgeon, either for disease or injury, and as that would be so much as to include the whole subject of tuberculosis and all kinds of injuries to the joints, I am not able or willing, and if I were there would not be sufficient time, to discuss the subject as a whole. It might be said, however, that there have been great changes in the surgical treatment of joints within a comparatively few years, as you are all well aware. This has arisen in a great measure from the fact that because of the great improvements in surgery since the introduction of antiseptic treatment of wounds the joint can be invaded and dealt with with so much less risk than formerly. That is one reason. And it seems to be a sufficient reason in the minds of a great many surgeons, that simply because joints can be gotten into and incised or scraped out, that is a good reason for doing it, and of course this must enter into the problem of whether such an operation should be done. Another reason why the joints are more frequently treated surgically now than formerly is owing to the changed views with regard to the chief disease which attacks the joint, namely, tuberculosis. Without entering into a discussion of the pathology of that disease, we are all, I believe, convinced that the former ideas with regard to it were not correct. I think we all believe now that it is an infectious disease and is not always inherited from the parent. We believe the trouble is usually of local origin, and there is a local focus from which the disease starts, and it is in that view, I think, that a great many operations are now done by surgeons who would have formerly looked with doubt upon the idea that the local focus of the tubercle can be taken away before it has found localities in other parts of the body. In my recent visit to Europe, both in Ireland and Scotland I saw surgeons there opening into the joints in cases where I am sure nobody here in the United States

would think of operating upon, nor do I believe they would be permitted to operate. I saw the joints of young people opened where there were none of the aggravated signs which we look for here, with a view of excising this local focus which it was believed existed either in the bone or in the joint. I saw, for instance, a surgeon, Dr. McEwen, of Glasgow, operate on a child about fourteen years old, able to walk without much limping, but afflicted with what we call the first stage of hip joint disease. I saw him cut into the joint and remove the head of the femur. In Ireland I saw a surgeon operating by what they call there an anterior procedure. In these operations they did it in the first stage of disease, before the disease had extended and made much or any destruction of the joints, but they do this operation on an entirely different principle from what I have been in the habit of seeing. They do it with the least possible violence to the joint; the head of the bone is not thrown out of its position. In both of these operations, Dr. McEwen did his operation posteriorly, making the usual incision from the crest of the ilium down from the joint, a short incision, and then introduced his chisel through an opening not over an inch and a half long, and by its manipulation, much pressure and lateral motion, he was able in a very short time to cut off the head of the bone, and then introduce his finger and extract the head. As I said before, I do not believe this would be permitted in our country. We see so little of joint diseases here, tubercular diseases, compared with what I saw in Ireland and Scotland. This is accounted for by the fact that the patients are not so well fed there. Among the poor in Scotland, the number of young people with joint disease is remarkable. Now, as I said before, I do not expect to be able to treat all of this subject, and I must say that I have had very little experience in the treatment of any of the joints, excepting that of the knee. I have had some experience in that, and have excised the knee some eight times, I think, and with seven successful cases. My friend, Dr. King, at the West Penn Hospital, has perhaps excised more, and has lost but one patient. I wish to speak of the difference between present practice and that in vogue when I was a young surgeon. I know of

no subject which shows the great improvements that have been made in surgery more than this one of the manner in which the joints can be opened. During our late war, for gunshot injuries of the knee joint there were fifty-seven operations performed, and of these fifty-seven, forty-four patients died. Mr. Otis, in his report of our late war, states that previous to the war there were some eighteen excisions of the knee joint, of which sixteen were fatal. Now, the operation of excision of the knee joint is one that is almost universally successful, that is, the patient seldom dies under the operation, and it usually results in a useful limb. In Ireland, where they do this operation a great many times, with great success, I was shown at the Richmond Hospital some twelve cases that Dr. Thompson had in the hospital under recovery. He told me he had done the operation forty times, with only one death, so that no doubt the operation is one recognized as proper, when formerly amputation would have been in all these cases considered the proper course.

When I look back upon my practice, even as late as when I became surgeon of the West Penn Hospital, within twenty years, I can remember patients who lay there for a year or two years with white swelling, as we called it, and eventually perished. I have seen some of these cases amputated, and I have seen several of them succumb simply from the confinement and the inability of the doctors to do them any good. Now these cases would not be permitted to stay there two weeks before some surgical operation would be performed for their relief. As you know, a local focus exists in tuberculous disease; it may be necessary to incise the joint, but in other cases, when only the synovial membrane is involved, the operation of arthrotomy may be performed; opening the joint up widely and dissecting out the entire synovial membrane and scooping out with a gouge any local focus that may be found. The disease I do not believe ever commences in the cartilage. I desire, however, to state at this time, and it is probably all that is necessary for me to say to you to show the method that Dr. Thompson uses to the knee joint, after having opened it, that this is much superior to anything that I have seen, although it is a good deal like the apparatus which I use myself.

I have brought it with me and will show it to you. In operating on a knee joint, they are in the habit of making what is called the horseshoe incision. This is made by commencing well back, and carrying the knife downwards and upwards across to a corresponding point on the opposite side, the joint opened, and if it is only desired to perform arthrotomy, the whole of the membrane is scraped with a scoop and cut away with the scissors, and then the flap is replaced. But if, on the other hand, it is desired to perform excision of the joint, the bones are cut off and fastened together with nails and a splint. The design of those who operate by cutting parallel with the articular surface is to leave the limb at the same relative angle. Dr. Thompson and those surgeons who have had the most experience in operating tell me that it is not the proper way to make the section of the femur; he makes the section of the femur at right angles with its axis, so as to make the leg perfectly straight, as it is in the normal leg. I am inclined to believe that is the better way. I will not go into the manner of cutting the bone, as the surgeons all know that as well as I do. The best way of fixing the limb, that is the important part of the operation. I presume part of the success of this operation in recent years had been owing to this fact. Older surgeons had been in the habit of using wire and other appliances, which did not accomplish the purpose very well. I believe the idea of doing anything to keep the parts in apposition originated in Germany, by the use of steel nails driven with a mallet into the bones. I do not think that was as good a means for keeping the bones in place as the one suggested by me. In Ireland they use silver pegs about an inch and a half long, after making a hole with the bradawl. The nails which I use are four and a half inches long for an adult. They are made for me by Mr. Helmold, and according to the pattern of Mr. Wyeth. The nail should be tapered so that it binds as it proceeds. Three nails should be used. Then hold the bones in perfect apposition with the assistance of the external apparatus. The apparatus which Dr. Thompson uses, and which I think is the best way to hold the limb steady, is made from common hoop iron, an inch and a half wide. This is easily manipulated; it is simply wrapped

around with a bandage over it to hold it in place, an anterior and posterior splint. The posterior splint is put down around the ankle joint and up on the foot, the anterior one leaving a space for the dressing over the knee joint, and after the operation it is not disturbed for three weeks, unless the elevation of temperature is over 100° F. There is a drainage tube put in across the joint behind the bone, well down, and usually it is a very successful operation. I could relate some of my cases, but I will not trouble you with that; the time is passing. I will however mention a case that I operated upon at the West Penn Hospital, a man 47 years old, a miner, suffering with disease of the joint. Although in this case I feared the operation could not be very successful, the man made a remarkable recovery. He walked into the operating room four weeks after the operation with a cane, and left the hospital in eight weeks. He had been suffering for two or three years. I received a letter from him three months after he left the hospital. He said: "With the greatest of pleasure I let you know that I am walking without crutch or cane. It was on the 5th of February that I walked. I was very much surprised at myself when I did it. From the day that you operated on my knee until the day that I walked was four months and eighteen days. How is that for an old man? Therefore, I thank you most respectfully for your skillful operation on me."

The joints in which operations are the most useful and in which the surgeons now have the most experience and have done the most benefit are the knee, the hip and the elbow. Excision of the elbow for injury is a most successful operation; so is excision of the knee. But I will say, as I said in the beginning, that there are many surgeons who think that because excision of the joint is done with such safety there is a good reason for doing it. It should always be remembered, especially by the young surgeon, that an excised joint is an admission on the part of the surgeon that he is not able to cure it. As our knowledge of tuberculosis advances, and we are able to treat tuberculosis successfully in the lung, we will be able to treat it successfully in the joint, and operative interference will not probably be essential then. It should never be forgotten, as the very first principle in the treat-

ment of all joints, that the first consideration is rest, putting the parts at rest. If joints can be kept still even where there is a local focus of tuberculosis, if they can be kept still, and proper hygienic measures resorted to, many cases will never call for aid from the surgeon. I believe the improvement in the treatment of diseases rests in an early diagnosis, and early treatment. Having said this much with little regard for order, I leave the matter in your hands.

DR. DAVIS: The term surgical joints has been used to describe joints that call for surgical interference.

DR. STEVENSON: I have never made claims to being a surgeon, but I have been so situated that I have had to do a little surgical work. I practiced for twelve years in Westmoreland county; I was medical man, surgical man, obstetrical man, and so forth. I had charge at that time of the Penn Gas Coal Company's works, which employed some seven hundred men, and I necessarily saw a good deal of injury. I think the first case I saw after I opened the office was a compound fracture of the ankle joint, with dislocation of the tibia. After cutting and having two or three men exert all the strength they could, I could not get the tibia returned into the joint, so I found a meat saw and sliced off about half inch and got it reduced, and that man is walking about to-day. I saw not long after that a carpenter doing something with a foot adz, the corner of the adz striking him just over the joint, and penetrating the joint. When I saw him the synovial fluid was exuding. This being before the era of antiseptics it ended in an amputation about four inches above the knee joint. The man got well with the loss of the limb. I have no doubt the improved methods of treatment would have saved that man's leg. I saw another case which was probably a tuberculous joint. It seemed to start without any known cause, and after continuing quite a number of months, the joint suppurated and I found it necessary to amputate above the knee. That man was not so fortunate as the other, his general health gave way and he died, although the stump had healed and done fairly well. One of the first important things is the diagnosis. What have we? Now in joints, we have a great

many structures, there is bone, there is cartilage, there is synovial membrane and ligaments and the surroundings. Any or all of these may be involved, or none of them may be. We have what is called simulated disease in joints the same as we have simulated diseases of other organs. We may have a mimicry of disease in a joint, and this may simulate almost anything. It is a very important matter when a surgeon or practitioner is called to a lady, nervous, of inherited tendencies, want of stability, easily excited mentally, and finds that she is complaining of severe pain in her knee. You look at the joint, you see it is swelled; she says she cannot use it, you attempt to use it, she screams out with pain. No doubt it is very important to determine whether it is a hysterical joint.

The constitutional history of the patient may decide this, but if you have an inflammation of the knee joint, you will have local heat. Possibly, you will have constitutional heat. If you feel this joint and it is cool or clammy, and you take the temperature of the patient, and you find there is no fever, there is strong ground for suspecting that you have no chronic trouble in the knee joint.

DR. BATTEN: In speaking of operations for joint diseases I will not go into a discussion upon surgical treatment. I believe it has been established that these diseases are of a scrofulous nature, and it was believed that that was a fact up to the time that Koch discovered his bacilli. Since that it is believed that the tubercle bacilli caused all these conditions of the joint, and that they are not hereditary. There is a question in my mind whether they are not hereditary. I believe the bacilli can be carried from the mother, a phthisical mother or a scrofulous mother, to the infant. However, that is a question. But there is one case I know in which an operation was not performed. It was a boy about ten years old, whose parents were living. He had what was called white swelling or inflammation of the knee joint. He was placed under the care of a great many physicians or surgeons, but there were no operations performed, and he finally recovered from this condition, and is at the present time using all the joints and is an active, healthy man. I would say,

however, that Dr. Murdoch is deserving of a great deal of credit for the manner in which he performs these operations, and the success that he has had in giving relief to the patients upon whom he operates.

DR. KÖENIG: In surgery, I think we all admit, cleanliness ranks superior to godliness. In view of the recommendations that Dr. Murdoch has made of a certain instrument—the little household utensil with which he inserts his nails—it seems to me that we must accord him greater godliness than cleanliness. With his well known ingenuity he should be able to construct some appliance capable of being made aseptic, after which he would have no occasion to recommend the use of an instrument as crude as the one he has shown us.

DR. LANGE: I have recently seen a few surgical points. I will relate one or two cases. A boy about eight years old while playing on the carpet screamed, said he had hurt his knee, and when his mother got it uncovered, she found on the most prominent part of the knee a single drop of blood, which was wiped away and the little fellow moved around the house, but limped. His mother instituted a search for needles and found half a needle with the thread in its eye. The accident did not seem to trouble the little fellow much until the third day. Although there was no swelling and very little heat, there was a good deal of pain, and when called, I considered it probable a piece of the needle was in the joint or about the joint, and that it would be the proper thing to anæsthetize the boy and attempt to remove it. This was done, a careful search was made for the piece of needle for more than an hour and a half. The joint, however, was not entered. After that, the little fellow was put to bed and his limb on a straight wooden splint; he was kept in that way two weeks and then allowed to get up. He was up about a week and was again seized with pain and this time a distinct fullness of the joint. The four depressions at the four corners of the patella had disappeared and were replaced by four convexities which fluctuated.

The leg was put in plaster and all motion of the knee joint was prohibited by the plaster for three months. Then the plaster



was taken off and the boy beginning to be active, there was again a slight swelling of the joint, and the plaster was reapplied and kept on for a couple of months more, and then taken off; and finally we saw the end of that surgical joint. The needle has, in all likelihood, become encysted, and will likely do no more harm. The other case was that of a boy riding his velocipede and falling with it. He was picked up and carried home, and when his doctor saw him he concluded he had a dislocation of the femur, because the leg was fully an inch and a half or two inches longer than the other, and because it was rigid, immovable and painful. The doctor chloroformed him, and attempted to reduce the dislocation, and thought he had succeeded. He applied a bandage to the boy's thigh and pelvis, and put him to bed, and the boy complained very little for two or three days. After this the doctor took off his bandages, examined the limb, and found it was fully two inches longer than the other. It was then I saw the boy and examined him under chloroform as the doctor had done. The curious part of the case was that when the boy was anesthetized his limb was the same length as the other, and it was evidently not dislocated; but when the boy came from under the influence of the anæsthetic, the limb lengthened two inches. The parents sent for additional counsel, and the last medical gentleman called in concluded that the boy had hip joint disease. We could not make a diagnosis, allowed that to go, and put the boy to bed.

He was kept there two or three days, then got up and walked, and had no pain or deformity. On a later occasion when I saw him he complained of pain, and again his leg was apparently two inches longer. We examined him very carefully, and we found that this was a simulated disease, that, as my friend, Dr. Stevenson, has characterized it, it was an hysterical joint, and that the lengthening was not between the pelvis and the femur, but was produced by muscular tilting of the pelvis. The length from both anterior superior spinous processes, to corresponding points below, was always the same, even when the leg projected two inches beyond its fellow. On the other hand, a line from one anterior superior spinous process to the other is not at right angles

with the body, but two inches lower, on the side where the leg seems longer. This boy is now actively about, painless and straight; but when he is cross, willful, or disappointed, he complains of his hip, tilts his pelvis, and lengthens his leg.

DR. GREEN: Dr. Lange's case reminds me of a surgical joint with which I have had some trouble. The patient, whom I have been called to see many times, has the power of dislocating the lower jaw. She is a girl of nine years; she has always been notorious for will power. Her mother told me that from childhood, whatever she asked for had to be given her. She would say: "If you don't give it to me I'll stretch," and immediately, were the request not granted, the child would begin to "stretch," and open her mouth just as wide as she possibly could, until her jaw would slip out. About two months ago I replaced the jaw; whether she has done much stretching since that time I do not know. I have known some persons who frequently had dislocations of the lower jaw, but in no other case have I seen a person who could willfully, maliciously, bring about this condition of affairs by stretching, and this boy of whom Dr. Lange has spoken reminded me of the spoiled child who "stretches."

DR. BUCHANAN: I understand the subject of the evening to be surgical joints, and those, I presume, are joints which are subjects for surgical treatment, either from disease or accidental injury. Vast improvements have been made in the treatment of injured joints within the last ten or fifteen years. It is within my recollection when a simple puncture of the ankle joint, and an injury requiring amputation of the anterior part of the foot, would have determined a Syme's operation, or an amputation of the leg. So great stress was laid upon the fact that *a joint had been opened*, and I believe this to be true with very many medical men to-day, that, when called to such a case, the question of amputation rises strongly in their minds. It is well known to-day by surgeons that the synovial membranes can be treated in very much the same way, and with the same impunity as the tendinous sheaths, or any other of the soft tissues of the body. The thing of importance is, when these cavities are open, to keep them aseptic. If this is done no harm can result from the opening, and in the

case of the joints we have exactly the same means of keeping them aseptic as in the case of the peritoneal cavity, and we can, in addition, if desired, use antiseptic solutions. Now, we are constantly called to dress injuries of joints, particularly fractures of the bones which go to form the joints; and I am satisfied that the practice will be in the future, in many cases, to open joints, wash them out, repair the soft parts, and wire the fragments of bone where the joint has been subcutaneously opened, and where the bones cannot be kept in apposition without great trouble, painfully pressing splints and firm bandaging. I am reminded of a case which Dr. Murdoch saw with me in consultation about a year ago. The patient had a simple fracture of the fibula and a fracture of the inner malleolus. I was called to the case and reduced the fracture without great difficulty, and was able to place the broken malleolus exactly in its position, and retain it there with a simple splint. Dr. Murdoch was called in consultation at the request of the patient, and, to my satisfaction, the next day. We endeavored to replace this dressing by another more permanent in character. This set up a frightful spasm of the muscles of the fibular side of the limb, and the spasms were so great that, using all our force, we had not the power to overcome them and place the limb in shape. I never saw a patient suffer more than did this patient for a few minutes. These sharp-edged fragments threatened to break through the skin and form a compound fracture. I proposed at that time, although the patient refused to listen to any suggestion of the kind, to make an incision over the point of fracture, and put in a single silver wire to retain the inner malleolus in position, and the pressure of an ounce or two ounces on the silver wire would perfectly keep the bone in position. Having to start with a simple fracture, having made the wound ourselves, we could keep it aseptic, no harm could come to the joint. I believe the time will come when that will be the ordinary treatment for such fractures in the neighborhood of joints, where the disposition to displacement is very great, where a very slight force exerted through a silver wire will hold the parts perfectly in apposition, and where we have every possible chance to keep the wound aseptic. There is an-

other aspect of surgical joints not dealt with very often, and that is the advisability, where there is doubt, of making an exploratory opening. I see no reason in the world why exploratory openings should not be made into joints when we suspect disease, as well as into the peritoneal cavity, and as often; but such openings are, I believe, very rare. With regard to cases reported this evening, of compound fracture of the inner malleolus and fibula, in which there was protrusion of the shaft of the tibia, in which the patient was etherized, and section of the tendo Achillis made, and a piece cut from the end of the tibia to facilitate reduction, I would say that I reported to this society a year ago a case exactly similar in all respects. I did not find it necessary to do a tenotomy, and the bone was returned without sawing any of it off, and I can hardly imagine a case of this nature in which the same result could not be secured, providing the opening in the soft part is sufficiently large to let the bones slip in. Muscular action is the only thing that would prevent the return of such a bone, and it can be completely abolished by anæsthetics.

DR. DAVIS: All cases of joint diseases present certain characteristics peculiar to themselves, and require good judgment on the part of the surgeon at the time, and can scarcely be discussed in a general way, but there are joints that are difficult of diagnosis, that no doubt give rise to a great deal of distress to the patient and give rise also to a good deal of distress to the attending physician, because of the long continued suffering involved. The youngest practitioner is likely to come in contact with such joints. One of the very important questions in such joints is when a surgical operation is advisable, or whether it is advisable at all. Take, for instance, the tuberculous joints referred to. The question comes up, when to operate upon it. Will the opening of these joints remove the diseased tissue? Will it give the patient a better chance of life? It is but a few years since all cases of hip joint disease were considered the property of the surgeon. We have heard to-night of this being carried to extremes on the other side of the water, and operations

done which would not be allowed here, and yet in looking at the statistics this operation on the hip-joint has not been satisfactory.

In the first place, quite a large percentage of those operated upon have died ; perhaps not directly following the operation, but within a few days or a few weeks after it. And of those who have recovered from the direct result of the operations, over one-half have died where the diseases have been of tuberculous origin, in such a short time that it is questionable whether the operation does not hurry the general disease. I have read somewhere that out of 388 cases of hip joint disease operated on, only sixty-one presented results that could be called satisfactory. Of these sixty-one there were about forty that had motion in the joint. Of the forty there were about ten who did not have to use artificial means, such as crutch or cane in walking. Results such as these are not flattering for the operation, and do not lead us to hurry or advise our patient to go into the hands of the surgeon and submit to the operation so liable not to be favorable in its outcome. And then in regard to operations on the knee. While we know that under aseptics it has improved wonderfully as regards immediate death, yet the cases especially where it is tuberculous have not done as well as we could wish. And so of the ankle joint. I have in mind now a tuberculous ankle joint where operations have been advised over and over again. I do not know but that if this young man would submit to the operation, and have all this bone removed, the confinement in the house would hasten his end. It is difficult for me to know whether to advise an operation or not. The difficulty with the general practitioner is to know whether to turn such cases over to the surgeon, and with the surgeon to know whether operation ought to be resorted to.

DR. MURDOCH : I think the surgeons who are in advance in this matter of treatment of joints are tending toward diminution of operations at the late stage, where there is great injury to bone. Patients in that condition do not recover well from an excision of a joint, and I believe the tendency of the better surgeons now-a-days, would be to recommend radical measures in joints such as Dr. Davis has described. If the bones are exten-

sively diseased, and the joint extensively involved, the patient would be likely with an excision, to perish from a general giving away of the system. I fully believe that such surgeons as McEwen, of Glasgow, and Barker, of London, and the surgeons most in advance, operate early, when the disease is local, and before it has yet attacked the synovial membrane, then is the time to operate at the earliest stage, when it is possible to remove the disease, and it can then be removed through a smaller incision without disturbing the relations of the joints, and a movable articulation may then be possible. In Ireland and Scotland, where there are hundreds of these cases to one here, the people have been educated up to the necessity of not allowing this disease to go on, and are willing to submit to an early operation. I am very sure the people here will not submit to the early operation thought proper there. I believe that it will yet come to be the proper practice where a diagnosis can be made sufficiently early. I will say to Dr. Koenig that if he will come up some time to my operations, I will show him how to do the operation, and how I have been so successful in preventing infection of the wound with the washouts I use.

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#### ATLANTA SOCIETY OF MEDICINE.—Oct. 6, 1891.

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This was the regular evening for the report of cases.

DR. HARDON reported an interesting case of twin pregnancy with placenta prævia, which he saw in consultation. When he arrived there was profuse hæmorrhage, large pool of blood under the patient, face blanched and pulse weak. Upon examination, found the os dilated to about size of a half-dollar, and could feel placenta with finger. Under chloroform passed whole hand into womb. After passing edge of placenta, hand encountered feet, and at the same time a head, and he at once diagnosed twin pregnancy. Tried to pull down feet but they would not pass the head of other child; so he again passed his hand and turned the second child, when delivery was accomplished without further trouble.

DR. COOPER reported a similar case, in which there was one very large placenta (twice the usual size), and a very long cord.

DR. CRAWFORD said that some weeks ago a child, one week old, was brought to him with ophthalmia neonatorum. He ordered silver nitrate, ten grains to the ounce of water, and a solution of bichloride of mercury, 1-10,000, with instructions to wash the eyes frequently with latter, and to return to his office daily for application of the former. Instead, the mother washed the eyes with the silver solution, and dropped the bichloride in the eyes. We would expect injury to eyes from such treatment, but child returned in one week and eyes were well.

DR. CRAWFORD also reported a case of natural absorption of cortical cataract in child fourteen years old. Lens almost entirely absorbed. Only about fifty such cases on record.

DR. HUTCHINS reported case of chancre of finger in a man, aged forty-eight. Six weeks before seeing him patient had little sore on finger, said to have begun as a boil. When seen there was a raw sore, size of a quarter, with some suppuration. For long time could get no satisfactory history. At last patient said he had acted part of midwife in labor case, and it was afterwards learned that husband of woman had sore on penis. Eight weeks later patient had macular eruption on abdomen, and papular on forehead. Sore is not healing and seems to be phagedenic.

DR. ELKIN said he had known of two cases of chancre of fingers, both in physicians. Both were contracted in making examination of women suffering from secondary manifestations and mucous patches in the vagina. In each case the infection took place in a "hang-nail." Reported further, some cases of syphilitic paralysis. In one case he saw the primary sore, and in three weeks eruption appeared; but the patient became careless of his treatment, and in four or five months left it off entirely. Then developed iritis, for which he took treatment for a few months, and then stopped. In two years had left hemiplegia. Dr. Elkin thought that if treatment had been properly carried out complications would not have occurred. He would impress the importance of a positive diagnosis before beginning general treatment.

so as to be able more fully to impress the patient with the necessity of following the treatment a long time and continuously.

DR. COOPER told of two cases of tertiary syphilis, in which there had been neither diagnosis nor treatment. Patient, aged thirty-six, gave no history of syphilis but said that six years before he had sore on penis, which physician said was due to irritation from clothing. Upon examination, found cicatrix on foreskin, supposed to be that of old chancre, and another just above knee. On posterior aspect of leg and ankle were eight sloughing ulcers, varying in size and depth, and surrounded with livid skin. Put patient on iodide potash, and applied local treatment to ulcers. Kept him in bed two weeks. Healthy granulations sprang up rapidly, and in thirty days all ulcers had cicatrized. Also reported enlarged testicle from syphilis, complicated with hydrocele. Tapped the hydrocele. Was a distinct cavity in upper part of testicle. Tumor was eight inches in circumference and of stony hardness. Diagnosis: Carcinoma or tertiary syphilis. Referred case to Dr. Elkin, who thought it syphilitic. Used anti-syphilitic treatment, and in two weeks tumor was reduced in size one-half. Lost sight of patient for long time, when he came to office for severe headache. This supervened about two weeks ago upon discontinuance of iodide potash. There were also vertigo and disposition to fainting. Resumed the iodide. Testicle now normal, with exception of slight hydrocele.

DR. McRAE showed specimens of bone removed from substance of brain in injury to head. There were entire absence of shock and other symptoms usually seen in such cases. Skull was crushed in just posterior to coronal suture. As the depressed bone was denuded, thought best to trephine. No bad symptoms at any time, and patient made rapid recovery. Further reported case of lateral operation for stone. Patient, aged three years. Four or five soft phosphatic stones situated in anterior urethra; one impacted in neck of bladder. Removed former with forceps through meatus. For the latter did lateral operation and washed out bladder. Child well in twelve days.

DR. GRANDY reported case of calculus removed from fossa navicularis, through meatus. Stone phosphatic and about diameter of No. 30 sound. Patient, aged 42, and very hysterical.

DR. L. P. KENNEDY reported a premature birth. The seven-months child, though feeble, was doing well, and had fair promise of living.



## Correspondence.

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### LETTER FROM BERLIN.

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BERLIN, August, 1891.

*Editors Atlanta Medical and Surgical Journal:*

After leaving London, a short stay of nine days was made in Paris, where there was much of medical interest seen, but chief of which was Apostoli's clinic, who treats all uterine disorders by his method of electricity, and which, in the various uterine hemorrhages, has been of much value in his practice, and of other physicians also, and should, in many of this class of cases, be used before a resort to surgery. The eminent surgeon, Pian, made a vaginal hysterectomy and removed a uterine fibroid and restrained the hemorrhage by the use of hæmostatic forceps, which were left in the vagina about two days; operated for an aneurism of the thyroid artery by placing a forceps on either side of the aneurism, which were removed in forty-eight hours; amputated at the hip joint and compressed the femoral artery with a forceps also, which he removed in seventy-two hours. This is his method: He never uses silk or catgut to restrain hemorrhage—always the forceps. The wound is dressed in the usual aseptic manner, covering the forceps with gauze and cotton bandage.

Berlin was reached very early in June. From that time until now, the surgical clinics of all the eminent specialists have been visited daily, some by payment of the price required, and some by the courtesy of personal invitation. From both sources one can have abundant observation and instruction. The material is abundant and absolutely in the hands of the surgeon, and students can examine and reëxamine. The patient takes it as a matter of course. And this applies as well to diseases of women as other diseases. In America, the women are somewhat averse to pub-

lic examination and treatment, but here it is not true, and for this reason the opportunities for study in this department are surpassingly good. No such thing as a sheet to cover a woman during an examination is thought of, and the universal position of the examiner is between the legs of the patient, and is better than the usual method in America, at the side.

The leading men here in surgical gynecology are Olshausen, of the University, the successor of Schroeder; Gusserow, of the Charité, and Martin, with his private clinic.

As abdominal surgery is the department in which the greatest advance has been made in the past few years, and the principles which underlie it are those which will apply to all surgery, and as its technique is of importance, one cannot give more interesting matter than to describe in a measure these men and their methods.

Martin, as every one knows by reputation, is a very large, fat man, blind of one eye by some casual injury. He has a heavy, coarse face, which is a true reflex of the man. He is not personally popular in Berlin, and here is not so famous as either Olshausen or Gusserow. He is also not popular with his students. He gives private courses of one month, for which one pays a very reasonable sum, and when one takes this, letters of introduction are not needed, and mine was not presented, so, as I received no courtesies from him, having paid for what I saw, these remarks are not improper. He and his female assistant are surely a wonderful pair. He operates every day, and one can stand for hours and see kolporophies, and perineorophies, and uterine curettements, and cervical amputations made in rapid succession. No man can use a needle and catgut like Martin. He is a wonderfully rapid operator. All of his operations, except laparotomies, are made in the ordinary operating room. The patient is chloroformed on the table. She is then brought well down to the end, with the nates projecting a little beyond the edge; the vulva is shaved by his woman assistant, the parts and surroundings well washed with soap and water, and then with a solution of bichloride, the vagina being cleansed by the fingers thrust in and the sides separated, and water copiously

poured in, the fingers meanwhile rubbing and scouring every part of it. An assistant takes each a leg, which is carried well back and put into a rest, which brings the patient into an exaggerated lithotomy position. Martin, with a long rubber apron, takes a seat in front, puts the end of the apron in a large vessel under the end of the table, puts his short and wide-bladed speculum in the vagina. If he is making a kolporophy, with a long bullet forceps he draws down the uterus, gives this to an assistant, who holds it vertically between the legs, and in the same grasp the straight point of an irrigator, from a vessel holding sterilized water. The lowest point of the proposed removal of mucous membrane is grasped by another forceps, given to assistant No. 2, who holds it vertically downward. The free hand of each assistant holds the side retractors that are put in the vagina. He cuts out rapidly, and without attention to bleeding, the tissue, and with a curved needle threaded with catgut makes a stitch at the apex of the incision, ties it, leaving the free end long, which he gives to the assistant, who now removes the forceps, and makes traction with this catgut. He then proceeds to approximate the sides of the cut by the continuous buried suture, thus building a support from the vaginal tissue, which may require more than one layer of the buried suture before the mucous cut surfaces are sufficiently approximated to bring them together with but little traction. If he is making an operation for rupture of the perineum, he fixes the four points of the parts to be vivified with as many bullet forceps, which his assistants hold, dissects rapidly, and builds from the bottom by the buried sutures, as in the kolporophy, so he does not use the long perineum needle for the usual deep and interrupted suture. If the rupture is complete, he will put in one or two deep silver wire sutures. He will make a vaginal hysterectomy in from thirty to forty-five minutes, while all of the other operators do so in from fifty to seventy-five minutes. With his short, wide speculum pressing the perineum, the retractors on either side of the vagina all being well drawn up, he fastens the bullet forceps through both lips of the uterus and pulls this well out. He then cuts into the posterior cul-de-sac, passes in his finger, and with the point

of this well against the body of the uterus pressing out toward the vagina, he passes catgut with a sharp-pointed curved needle (his finger acting as a guide to the point of the needle and its depth) and ties every particle of tissue with many different ligatures in advance of his incisions, which he makes with curved scissors. So soon as he can, he draws the fundus uteri without the vagina, inverting completely the uterus, and makes the separation from the bladder last. The ligatures are cut short, the vagina is filled with iodoform gauze, and the operation is complete. The hemorrhage is almost nothing, and what there may be is washed away by the slow stream of the irrigator. He has no sponges or gauze to remove blood during his operations.

His ovariectomies are made in a special room, as is the case in every clinic in Germany. This room is heated to about seventy degrees or more. Every spectator strips himself of coat and vest, but puts on no white coat. He evidently has a pride in the rapidity of his operations, for as soon as he has passed the last stitch he asks an assistant, who takes his case history, how long the operation has been. He sits directly between the legs of his patient, which hang on either side of him, and makes a long cut from the umbilicus to near the pubic bone, and pays no attention at all to the parietal blood vessels. When the peritoneum is reached, he grasps a bit of it with two sharp pincettes, an assistant takes one, and between them it is cut through with the scissors, two fingers are inserted, and with these as a guide he cuts rapidly the entire wound. If the tumor is cystic, he cuts a pus opening with a bistoury and pulls the incision over the side of the abdomen until it is well emptied, and takes no special pains to prevent the contents from getting into the peritoneal cavity. The intestines are held out of the field of operation by an assistant with a large, flat sponge in the peritoneal cavity which has been sterilized and then boiled for four hours in olive oil. The bleeding from adhesions which he tears with the hand are tied with catgut. The pedicle is fixed by catgut sutures, several of which he will pass, owing to the size of the pedicle, and each tied separately and in sections, and then the ends of the central one passed entirely around and tied. The pedicle is

dropped into the cavity, which is then cleansed with sponges from sterilized water. No antiseptic or antiseptic purified instruments go into the cavity. In closing the abdominal wound, he uses stout *silk*, by using five, six or seven [deep interrupted sutures, the entrance and exit of which are an inch or more from the cut surface, and the course almost perpendicular until near the peritoneum, through which it passes quite near the cut edge. These are tied, and the skin edges brought together by the *continuous* CATGUT suture. A little iodoform and iodoform gauze are put on the wound, and over these some cotton batting is bandaged very securely.

The time required to make a laparotomy is from eight to forty-five minutes. This last was a very large uterine fibroid. The incision was made beyond the umbilicus, and as there was free, uncontrollable hemorrhage from the vessels of the tumor itself, he cut this off near the pedicle, and then with forceps and catgut entirely around the pedicle he restrained the bleeding, and dissected out the remaining portion of the tumor in the usual way. The body of the uterus was removed and an opening made in the anterior cul-de-sac, through which the free ends of the numerous ligatures used were brought, to act as a drain through the vagina, which was well filled with iodoform gauze.

In his clinic there was a young woman who had had an ovary removed in 1889 and the other in 1890, for excessive uterine bleeding, and she came now for a continuance of this. The uterus will be curetted, and by the repeated injection of strong solutions of zinc chloride an effort will be made to close the uterine cavity by granulation. Here is a case where surgery failed to relieve a uterine hemorrhage, and just the class of cases in which Apostoli, and at present Thomas Keith, who uses the Apostoli method, claim that they obtain such markedly good results from electricity.

Olshausen is the successor of the famous Schroeder, and is universally, personally and professionally esteemed. He is in appearance and reality a gentleman.

He does not operate so rapidly as Martin, but more carefully. The antiseptics of each is the same, with perhaps some more care

on the part of Olshausen. In his vaginal and uterine operations, he uses never a sponge, but gauze sterilized by steam, and once used is thrown away. This he also uses in the peritoneum in his laparotomies. Catgut is this universal suture and ligature. He builds from the bottom with the buried suture in perineal and kolporophy operations.

Hysterectomies he makes by incisions entirely around the cervix and carefully cutting with scissors and dissecting with finger, and usually separates the tissue equally all around, and enters the peritoneal cavity first, sometimes anteriorly and sometimes posteriorly. He passes his hæmostatic sutures with a long, curved aneurismal needle, and seeks soon to tie the two laterel uterine blood vessels with the round ligaments. He uses less sutures and less cutting and more turning than Martin, but his operation is not so bloodless and rapid. His incision through the abdominal wall in laparotomies is carefully made and the hæmorrhage stopped before the peritoneum is opened. Bleeding from torn adhesions is tied by catgut, and the pedicles are treated in the usual German way—ligation in sections. The peritoneum is sewed separately, and the abdominal tissue also, from the bottom, with the buried suture; the skin last.

One day his assistant, Dr. Winter, made a vaginal hysterectomy. He divided tissue before he had passed the preceding hæmostatic ligature, from which there was free bleeding. From repeated attempts he failed to tie this part, as it was deep in the pelvis and against its wall, though he could catch it with the forceps. He tamponed, toiled half an hour, opened the abdomen secured the vessel, and the patient got well. Here was a case where he should have let the forceps remain, after the method of Pian.

In company with a prominent gynecologist of Chicago, a stay of three days was made at Leopold's Clinic, of Dresden, in response to an invitation in reply to a letter asking if we might visit his hospital. He is quite a young man, being only forty-five years of age, and is exceedingly courteous to visiting physicians. He has made, perhaps, more Cæsarean sections and with better results than any other operator, but even his results are not so

good, either as to the number of women and children saved, as by the premature induction of labor and the use of an incubator in which a five months foetus will live and thrive. Leopold heads the list in the number of his vaginal hysterectomies, having made very near two hundred, with a mortality of less than 5 per cent. Eighty of these were made for carcinoma, forty-five of which are living two years and longer after operation, the longest being seven years. It is presumed in carcinoma cases that if there is no return in two years it is cured.

His entire hospital is a model of cleanliness and antisepsis. He uses great quantities of bichloride. In the lying-in wards a vaginal examination is never made, as the position of the child is diagnosed by external touch. We saw him make a laparo-hysterectomy for carcinoma. The patient was placed in Trendelenberg's position (the hips elevated at an angle of perhaps forty-five degrees). The abdominal incisions were made boldly and with but little care as to the bleeding, the uterus with surrounding carcinomatous tissue isolated, in doing which it was necessary to dissect it from the left ureter, and large attachments to the rectum also. When this was complete, an opening was made through the vaginal vault and iodoform gauze stuffed in, the abdominal wound closed, the patient's hips lowered, and the operation completed by removing the organ through the vagina, some of the wall of which was cut away, into which the disease had extended.

Leopold makes all of his laparotomies with the hips of the patient elevated, and one is pleased at the perfect view one can have of the pelvic viscera. The intestines fall down toward the thorax and require no holding and do not fall out.

I have seen Olshausen remove suppurating tubes that were firmly adherent *in situ* with this position of patient, and it seems to me that it is a comfortable one for the operator. Certainly the view is perfect.

Leopold uses nothing but silk in his operations, and does not use the buried suture in his kolporrophies and perineorrhies, and because the stitches have to be removed, is not so good as catgut.

He has a new operation for obstinate retroversion of the urethra, the first of which we saw him make, which he hopes to be able to substitute in many cases for ventral fixation. Briefly, it consists in encircling the entire uterine cervix with an incision well through the mucous membrane, and then from that one, and at right angles to it, another on either side of the cervix its entire length, with the finger chiefly dissecting the mucous membrane anterior and posterior, well up to the body of the uterus, the extent of the lateral incision.

Where the lateral cervical incision begins a slant suture is inserted and brought out, carried up to the highest point of dissection, inserted and passed buried to the opposite side, in front of cervix, brought out again, and then carried down and passed through tissue on the opposite side to where it was first inserted. This parallelogram of ligatures, drawn upon, brings the upper anterior part of its dissected surface down to the incision over the mouth of the cervix, and as the cervical edge of the flap is held also by the suture, it folds this on itself and bulges it, so to speak, forward and shortens the anterior surface of uterine mucous tissue. This pulls upon the fundus and draws it forward and stretches the posterior dissected surface, which is left to heal by granulation, and acts as a posterior stay to the womb.

All in all, Leopold is perhaps the best operator I have seen. He is rapid, sure, scrupulously clean, and makes the prettiest and neatest incisions and the most perfect approximation and stitching.

My observations since in Europe have convinced me that for all abdominal operations catgut suture and ligature is better than silk, because it is absorbed and cannot act as a foreign body, and because silk is not absorbed and may be a foreign body. The objection that catgut is unreliable by reason of its short life or absorption I am convinced is not well founded, and this is based first, upon Pian's use and removal of the hæmostatic, which proves that a firm clot is found in the largest artery in three days, and because of the almost universal use of catgut here and no accidents occurring.

However, as catgut is expensive, and the rapid formation of



thrombus is based upon a thoroughly aseptic wound, it is perhaps best that the average operator, in all other than abdominal surgery, should yet use silk, because the asepsis, not being so uniformly possible to the physician who does all work, a firm thrombus *might* not be found before the catgut is absorbed, and the silk can come away as a foreign body later and only prolong the time of cure. Abdominal wounds *must* be right or the patient is dead. Other wounds *can* be septic and the patient is only longer in bed perhaps.

I meet here such distinguished men as Wm. Goodell, of Philadelphia, seeing these men and their methods.

In future I shall hope to write of Hirschberg and Schwiegger, the eminent oculists, whose clinics I have visited daily, for two months, as they were at different hours; also of Von Bergmann and his surgery, perhaps.

I shall go to Vienna the last of September.

T. M. McINTOSH.

*Of Thomasville, Ga.*

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## OUR NEW YORK LETTER.

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NEW YORK, October 15, 1891.

At the last meeting of the Obstetrical Society an interesting discussion took place on the use of the forceps. A paper was read by Dr. Malcolm McLean, in which he stated that most cases which came to gynecologists traced their illness to child-bearing, and that operations "to assist nature," especially the use of the forceps, were largely responsible. He had seen many mistakes made in the course of an extensive experience, especially in regard to the time chosen for the application of the forceps, the manner of their application, and the kind of cases selected. Three cases were cited to illustrate these points.

The first was a primipara, aged twenty-six, who was confined at term. The presentation was normal, but the first stage was tedious. Eight hours after expulsive pains began the occiput

was low down and in the second position. The patient then insisted on having assistance. Chloroform was given, she was put in the lithotomy position, the external genitals were washed with warm carbolized water, and the bladder emptied by means of a glass sterilized catheter. The forceps were then applied, and the occiput brought down well under the pubis. Two fingers of the left hand were then passed well back on the perineum, one on each side of the coccyx, and the head held in position by them while the forceps were removed. The pains then lifted the head out of the pelvis gradually. This was his usual method of procedure in all such cases. The child was breathing feebly and the heart was weak, and in spite of every effort it died. The birth was normal in every respect except for the delay, but the mother became an invalid from pelvic peritonitis. In this case the forceps should have been used hours before they were. Such instances were not common in these days, the opposite procedure being much more frequent.

The second case was also a primipara, aged twenty-two, who had had an uneventful pregnancy. Labor began at 10 A. M., and at 3 P. M. the os was dilated. At 4 P. M. the long Elliot forceps were applied by the attending physician with great difficulty, and efforts made to deliver for three hours. Dr. McLean was then called, and found the head firmly impacted in the swollen tissues at the superior strait. The Farrier-Lusk forceps were applied, and delivery effected with great difficulty. In this case the forceps were manifestly applied too early.

The third case illustrated the use of the forceps in a case to which they were not properly applicable. The woman was a primipara, aged thirty, who was in labor at term. The first stage was tedious, and after the second had lasted several hours there had still been no descent. The attending physician then applied the forceps, the blades passing with difficulty, and locking being hard to effect. Traction was then made, but the head did not descend. Other forceps were tried, the first having slipped off but without avail. After two hours had been spent in useless effort, Dr. McLean was called. He found a well-formed roomy pelvis, into which he introduced his hand and by feeling the

child's ears discovered that he had an occiput posterior presentation to deal with. Rotation was easily effected, when the head settled down in the pelvis, and delivery was completed by the forceps. In this case if the hand had been introduced and the ears felt before forceps were applied much trouble would have been avoided. The forceps should never be applied at the superior strait without the introduction of the hand to ascertain the position of the head positively.

He did not regard restlessness in the first stage as a reason for the use of the forceps—nature was to be assisted, not violated. It was important to know just where to use the instruments and also how to use them. When the head was well down the blades could be removed, the fingers on each side of the coccyx grasping the head and holding it in position, and even lifting it from the pelvis. Rapid delivery was seldom necessary, and it was much better to be deliberate. The forceps were sometimes applied where version would be better because of disproportions. Nine times out of ten, however, version was not attempted until the forceps had failed, and thus the operation was rendered more difficult and was often complicated by lacerations of the uterus and vagina.

Dr. R. A. Murray agreed with Dr. McLean regarding the advisability of introducing the hand to ascertain the exact position of the head before applying the forceps. When the head was found movable above the brim the forceps were seldom applicable. When the cervix was not well receded over the head it was necessary to be careful to apply the forceps during the interval between the pains, to avoid injury to cervix.

Dr. Hanks believed that the forceps should never be applied when the head was movable above the brim. In such a case there was no indication for interference unless there was fever. In cases of occiput posterior position he had been able to make a diagnosis from the sutures and fontanelles, and had been able to accomplish rotation.

Dr. Chas. Jewett, of Brooklyn, stated that bad tears of the perineum were seldom observed in natural labors, but were usually the result of the forceps deliveries. In occiput posterior cases

the position should be corrected early. He had succeeded in doing this in some cases, only by carrying the hand past the head to the shoulder. This was quite possible with antiseptic methods. He thought that rapid delivery with the forceps was too common, and was very bad. The indications for the forceps were, in general terms, any danger to the life or health of the mother or child.

Dr. Buckmaster thought that a good indication for the use of the forceps was the failure of the head to recede between the pains.

In closing the discussion Dr. McLean expressed his agreement with Dr. Buckmaster in regard to the non-recession of the head. It was bad to allow the head to remain fixed in one position for any great length of time. Another point in regard to the use of the forceps was in the amount of force used. This was often greater than was necessary, if care be taken to allow the head to choose its own position, by holding the wrist loose, so as to allow the instruments to turn with the head.

#### THE TREATMENT OF EPILEPSY.

This bugbear of medical science was again under discussion at the last meeting of the Academy. Dr. B. Sachs introduced the surgical side of the question. He stated that much had been expected from surgical treatment, but little had been realized. Statistics on the subject were valueless, the failures not having been recorded and many of the apparent successes having been announced too early.

In considering the question of operation in any case, it must be remembered that epilepsy was in many, if not most, cases not idiopathic. He examined very carefully for signs of infantile paralysis which had recovered and for a history of some injury to the brain or skull. Since doing so he recorded fewer idiopathic cases. Recent pathological investigations also showed that, though the initial canal lesion could not always be discovered it was quite common to find a resultant sclerosis. This was especially true of cases of localized spasm, Jacksonian epilepsy. The initial lesion was usually a meningeal hemorrhage or an area of softening caused by an embolism, these

resulting eventually in a localized sclerosis. These conditions were in most instances found in the cortex. Where such lesions could be ascertained to exist, an operation for removal of the diseased area might be performed if the epilepsy were of the Jacksonian type, so as to render possible the location of the lesion. In children the function of the removed centre might be assumed by other parts of the brain; in adults, however, paralysis was inevitable, and the choice would have to be made by the patient. Cure of epilepsy could not be predicted in any case.

The prevention of traumatic epilepsy was a promising field for the operator. An immediate exploratory operation should always be made in cases of injury to the skull. If depressed bone were discovered its removal should be accomplished by the trephine. These operations on the cranium could hardly be regarded as dangerous under present surgical methods. Seven cases of epilepsy had been operated on by his advice. In all the operation was quite extensive, and there was not a single death. These were in adults; the result was different in children, three out of four cases which he had had operated upon having died.

Dr. C. L. Dana then took up the medical treatment. He said that, in view of the recent exhaustive review of the subject by Dr. Seguin, he would not go over the whole field but would confine himself mainly to some points in diagnosis which were useful as guides to treatment. Many epileptics showed signs of a chronic degenerative condition which rendered treatment hopeless. It was apparent in some cases in the general expression, while in others at the other end of the scale the epilepsy seemed but an accident. Certain stigmata, or marks, of the degenerative type should always be looked for. These were, in brief, asymmetry of the cranium, shortening of the parietal or the frontal arches, a sharp palatal arch, and badly set teeth, difference in the color of the eyes and in the position of the pupils, deformities of the ears from absence of the helix or from being badly placed, abnormally long fingers and a marked difference in the size of the two hands or feet, deviation of the nose, and flattening of the nasal bones. Sexual anomalies were common, and irregular

innervation in voluntary movements. Irresistible erotic tendencies and masturbation, irritability, viciousness and a lack of self-control were physical conditions sometimes noticed. Just in proportions as these features predominated was the hopelessness of treatment.

Hydrotherapy and mental occupation were of more real value than the bromides. The former was not sufficiently understood in this country. The use of phosphoric acid was a useful adjunct, as careful observation had shown that the excretion of phosphates was diminished in these patients. The use of anti-pyrine had been lately recommended instead of chloral as advised by Dr. Seguin.

Dr. J. A. Wyeth continued the discussion by describing the different methods of exposing the brain. He also stated that the operation could not be regarded as serious if performed under careful antisepsis.

Dr. W. R. Birdsall believed that the danger was much greater when portions of the cortex were removed. It was too soon, however, to decide on the value of these operations, as improved surgical methods were of so recent date. We were still in the experimental stage. He relied on the bromides with adjuvants such as the mineral acids and other tonic remedies. Numerous modes of treatment had been employed in the treatment of this disease. In 1800 a folio book of a hundred and fifty pages was given up entirely to the enumeration of those tried up to that date. The list had been lengthened since. As late as 1850, the menstrual blood of a virgin was seriously recommended. Operative procedures of various kinds had been tried, such as amputation of an arm, castration, and ligation of a carotid. The influence of mental impressions was almost as great on epileptic as on hysteria cases, and they improved after any operation or even change of treatment.

Dr. M. Allen Starr thought that operations should be confined to traumatic cases, and those in which the location of the brain lesion could be definitely located. Unfortunately, the majority of epileptics did not belong to these classes. He never advised excision of a portion of the cortex. Unless the area of sclerosis

were such as could be distinctly defined by means of an ordinary magnifying glass, the scar left by the removal of a portion of the brain would result in a more serious irritation.

He relied on the bromides. Recent investigations had shown that increase of uric acid in the urine often preceded a convulsive attack which could be prevented by appropriate treatment by alkalies, etc. In order to take advantage of this indication daily examination of the urine was necessary. He had been able to have this done in one case by a physician who was a victim of the disease, and it seemed as though there was truth in the statement and value in the treatment.

#### THE ABUSE OF MEDICAL CHARITY.

Some interesting facts pertaining to this subject were set forth in a paper read by Dr. W. H. Bates, at the last meeting of the Society of Medical Jurisprudence. It was stated that during the year 1890, the hospitals and dispensaries of New York treated 550,000 new cases, not to speak of the thousands treated by the Health Department. The same large proportion was noticeable in the other large cities. It was said that one-half the population of London asked for and received gratuitous medical treatment, and as large a proportion of the inhabitants of Edinburgh. The ratio was constantly increasing. Many persons sought dispensary treatment who were able to pay a physician a reasonable fee. Actual investigation had shown that forty per cent. of dispensary patients lie regarding their address, or their financial condition or both. This was a great wrong to the deserving poor, whose circumstances required that they seek aid at the dispensaries. The treatment received was certainly inefficient where from thirty to sixty patients were disposed of in an hour by one man, which was not unusual in the large dispensaries here.

The remedy suggested was the passage of a law making it a misdemeanor for a person to seek to obtain gratuitous medical treatment through misrepresentation. During the discussion of this suggestion the astounding statement was made and seemed to be generally agreed to, that the passage of such a bill would be opposed by the trustees of the dispensaries and hospitals, who occupied their position for some selfish end, and would not agree to anything that would diminish the number of cases treated. .

WM. L. RUSSELL.

## Editorial.

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Responses to our invitation, in the last number of the JOURNAL, for communications relative to the treatment of "common colds," one of which appears in this issue, encourage us to continue the feature. For the December JOURNAL we invite letters from our readers on their experience with, and treatment of, ACUTE BRONCHITIS.

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## ANÆSTHETICS.

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The recent discussion on anæsthetics, by the members of the Atlanta Society of Medicine, disclosed the same diversity of opinion as to the relative safety of ether, chloroform and the A. C. E. mixture, which has characterized similar discussions of the same subject by medical bodies in this country and Europe. Each gentleman preferred the agent with which he was most familiar, and which had given him best results; and while the consensus of opinion was in favor of ether, there was not that unanimity of sentiment in its favor to which its greater relative freedom from danger, in ordinary cases, justly entitles it. There are comparatively few surgeons of large experience, who have given both ether and chloroform a fair trial, who do not give ether the preference. Each is safer than the other in properly selected cases. Both require the undivided attention of an intelligent administrator, who has the capacity for winning the entire confidence of his patient, and explaining to him the disagreeable sensations which these agents produce. Too little stress is laid



upon the latter point by text-books and teachers. Surgeons usually select the least reliable assistant to administer the anæsthetic. The poor patient is frequently smothered by a cone or inhaler, without having received preliminary encouragement or instruction, and held down by brute force until the overpowering effects of the drug are obtained. Such an undertaking is often difficult of performance, and not altogether free from danger. Few things are more distressing to witness than the terror-stricken expression, and futile, though almost superhuman struggling of such a victim.

Mixed narcosis has a rather limited field for usefulness. The A. C. E. mixture certainly seems to be an unscientific compound, and of doubtful utility.

We are prone to jump at conclusions from insufficient data. We do not make due allowance for individual susceptibilities and idiosyncrasies. We may hope for an ideal anæsthetic, but in the meantime we must study each patient carefully, and administer to him that one which seems best suited to his particular case. The surgeon who does less is a culpable routinist, who sooner or later finds it out to his sorrow.

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## THE OPENING OF THE MEDICAL SCHOOLS.

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The medical schools of the country began the session of 1891-92, about one month ago, and work is now well under way. The opening of the two Atlanta schools was particularly auspicious and encouraging. It was thought and feared that the articles of agreement between the Atlanta Medical College, the Southern Medical College, and the Medical Department of the University of Georgia (see August number of the JOURNAL), whereby the tuition fee was to be raised to \$100.00, and rigidly

adhered to, would have the effect of greatly reducing the student attendance, and making many young men seek their instruction in other schools, which we might name, where they would be gladly received for the regular fee, if possible; for anything they could pay, if convenient; for nothing, if necessary. It is a source of pleasure and congratulation to the faculties of the Georgia schools that their fears have not been realized. The two colleges in this city never opened with better attendance, and were never so well prepared to do thorough and efficient work. The Atlanta Medical College and the Southern Medical College have each enrolled about as many men as were in attendance last session, and a few others will matriculate in each school. The new departure of the Georgia schools, above referred to, will greatly improve their clientele. We are pleased to note these indications of prosperity and progress. They are encouraging for the future medical education in the South.

It is still too easy a matter to obtain the medical degree. There are hundreds of men in college now, to be graduated next spring, and turned loose upon a too confiding community, who ought to be plowing a mule or carrying mortar. It is absurd for such "students" to attempt to learn any science, as they present themselves at our colleges, and most of all, the science of medicine. But they continue to receive their diplomas, the mere *possession of which*, in some States still—and Georgia must shamefully acknowledge the corn—qualifies the holder to practice his dangerous physic upon all those who unsuspectingly come within his reach.

In the matter of medical teaching two errors still exist in some of our colleges. The first is, that any man, with or without mental training and capacity, can pursue the study and practice of medicine. The second is, that any man, be he ever so bright, can qualify himself for practice by a two-term course of study,

of five, or six, or seven months each. Happily, these illusions cannot last much longer. The spirit of reform and advance in our medical education is abroad now, and an enlightened profession and an enlightened public mind are very wisely demanding more of both colleges and students.

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### THE DOCTOR'S BILL AND THE GOVERNOR'S VETO.

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We are very pleased to learn, just as we go to press, that that unjust and foolish measure known as the "Drunken Doctor's Bill," which passed both houses of the horny-handed Legislature, just adjourned, has received the Governor's veto. There were those among these rural Solons who were seized with such an intemperate zeal for temperance that they wished to make it a misdemeanor for a physician to become intoxicated.

With the printer demanding "copy," we have not the time to write a lengthy editorial. We have expressed our mind on this matter already. (See August number of JOURNAL.) The passage of this iniquitous bill was a reflection on one of the best and noblest classes of society, and we have been surprised that certain physicians in the Legislature gave it their support. We are glad that Governor Northen has put his disapproval on this narrow-minded and high-handed piece of legislation.

The Governor thus states his position:

"In this policy of legislation I cannot concur. Drunkenness on the part of practicing physicians and prescription clerks is reprehensible, and ought to be suppressed; but if it is a crime for them to be intoxicated, it ought to be a crime for others who get in like condition; and if it is no crime for others, it ought not to be a crime for them. It is the act of drunkenness that would be punished if this act were a law, and the acts arising from that

condition; and if drunkenness is the *gravamen* of the offense all persons should come under the same law. If not all, then none."

From this wise and broad view of the matter at home, let us turn to the criticisms which come from abroad.

The *N. Y. Medical Record* says:

"The Georgia law is an insult to the profession of the State, because its existence implies a serious and preponderant degree of intemperance among medical men. It is in addition a form of special and class legislation of the worst character. Under it, a doctor who has led a sober and useful life for a long time may, as the result of a single indiscretion, have his career ruined and his means of subsistence taken away. But the lawyer or editor or farmer can stay drunk for a year with relative impunity. If such a statute, therefore, really exists, the physicians of Georgia should see to it that it is repealed, or be convicted of possessing neither manhood nor self-respect."

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**HYDROPHOBIA AND SYNTAX.**—The good citizens of Connecticut have been considerably alarmed at the prevalence of hydrophobia among the dogs of the State. The following remarkable notice appeared in the columns of a Farmington journal: "By notice elsewhere it will be seen that any persons owning a dog in the town of Farmington are notified that they must be properly muzzled."—*Medical Record*.

Which reminds us of the notice the Georgia farmer posted on his premises: "If any man's or woman's cow or bull gits in this yere pastur, his or her tail will be cut off, as the case may be."

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**DR. W. A. CROW**, of Atlanta, is now pursuing a post-graduate course at the New York Polyclinic and Hospital.

**DR. A. B. McRAE**, of Seville, Georgia, is also at the Polyclinic.

## Selections.

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### LOCAL TREATMENT OF DYSENTERY

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There seems to be in modern medical thought a very strong tendency to consider disease as constitutional rather than local. I do not doubt but that there are one or more forms of dysentery dependent upon the presence of poisons in the blood, but I feel very confident that the dysentery, as we see it ordinarily in this climate, is essentially a local inflammation, independent of any blood poisoning. If this be true, the disease should be especially amenable to local treatment. It is true that the ordinary treatment, which seems not to be local, really owes much of its efficiency to a local influence. Thus, the purgative acts by a purely local depletion; the mercurial, or the ipecac, by a local stimulation of the glands involved; whilst the bismuth spreads itself upon the mucous membranes and by its local action lessens inflammation. It has seemed to me, however, worth while to draw the attention of practitioners to the value of the direct application of remedial agents to the affected parts.

Many years ago I published a series of cases of chronic dysentery, demonstrating the extraordinary efficiency of forced enemata containing one-half a drachm to a drachm of nitrate of silver dissolved in two or three quarts of water, and further experience has corroborated all that I said. Indeed, from time to time have appeared papers in the medical journals proposing the treatment as both novel and efficacious.

In acute dysentery, involving the colon high up, I have found large enemata, containing two or three drachms of subnitrate of bismuth, much more efficient than the exhibition of bismuth by the mouth. When the symptoms are severe, this local treatment may often be preceded with advantage by washing out the colon with large quantities of cold water. I have never used

injections of nitrate of silver in acute dysentery, although the effect of the local application of the nitrate in other inflammations of mucous membranes would justify trial of the remedy. I have seen, in one or two cases, large enemata of very hot water injected without affording relief, and believe that hot water enemata are, in their ordinary results, not at all comparable with large injections of ice-cold water.

When the lower part of the colon is affected, the local use of ice sometimes has an almost marvelous effect. I have, indeed, seen the whole aspect of a very severe and alarming case, in which the symptoms indicated that the colon was affected high up, changed in a single hour by the continuous use of *ice suppositories*. While it is not necessary to have the pieces of ice entirely regular in shape, care should be exercised that no sharp edges are left. The suppositories should be rapidly used, one being put into the rectum every three to five minutes, so as to get, for at least half an hour to an hour, the effect of the continuous application of cold.

When the tenesmus is very severe, iodoform suppositories are often much more efficient than opium in bringing relief.

A remedy which has been from time to time recommended very highly in dysentery, but has not, I think, been much used, is ergot; and when the passages contain large quantities of blood, or are nearly pure blood, the extract of ergot would seem to be indicated. I have never myself used ergot by the mouth in these cases, but have employed suppositories containing twelve grains of extract of ergot and four grains of iodoform, used every two hours until four or five suppositories had been taken with, seemingly, great advantage.

I do not mean to advocate the local treatment of dysentery as a substitute for the use of mercurials, purgatives and ipecacuanha, etc., but as a very important adjuvant to the older forms of treatment. Nevertheless, in my experience, the effect of local remedies has been more prompt and decided than that of drugs given by the mouth; but in cases of any severity the attack upon the disease may be made from each end of the mucous tract.

As illustrating this method of treatment, I give brief outline of a case seen very recently.

This was a middle-aged woman, an habitual patient of my own, who had been suddenly seized with violent abdominal pain and diarrhœa four days previous, during my temporary absence from the city, and came under the care of another practitioner of repute, by whom she was treated with mercurials, etc., *secundum artem*. I was sent for about 6 A. M., and found her in a condition of marked prostration, suffering from great tormina and tenesmus. She had had during the night six passages which were said to have been of the character of the one shown me. This consisted of about a teacupful of blood, mixed with just enough sero-mucous liquid to prevent clotting. Calomel was ordered by the mouth in one-sixth grain doses. Ice suppositories were freely used for half an hour, with great immediate relief to pain, and were followed at once by suppositories containing five grains of iodoform and twelve grains of extract of ergot, given every hour until four were taken. Two hours after the commencement of the local treatment the passages were free from blood. By afternoon the patient was without any abdominal distress, and the bowels were quiet; but during the night the calomel produced several characteristic fæcal discharges, containing a few scybala, on account of which a dose of castor oil was given. The operation of the oil ended the case so far as abdominal symptoms were concerned, and in sixty hours after the commencement of the treatment the patient had a normally-formed fæcal passage.—*Dr. H. C. Wood, Uni. Med. Magazine.*

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GONOCOCCI. Drs. Vibert and Bordas. (*La Med. Moderne*, Nov. 13th, 1890; Jan. 1st, 1891; and *Journ. des Mal. Cut.*, June, 1891.)

In the first article the authors attempt to show that the gonococcus has no value as a diagnostic sign in medico-legal cases where the nature of a vulvitis is to be determined. They found, to all appearances, indetical organisms in six instances where blennorrhagia in young girls was attributable to other than venereal cause. In the second paper are reported the successful attempts of the authors to cultivate the gonococcus. Positive

results were obtained upon bouillon, agar, and potato. The cultivations showed diplococci in all respects similar to the gonococci. Thus it would appear that cultivation is not sufficient to make the diagnosis absolute. If the observations of different authors are compared, it will be seen that they are not in accord either as to the best media for cultivations, the proper temperature, the length of time required, or the appearance of the colonies of cocci after they have developed. In the author's own hands the results have not been uniform.

They are, hence, of opinion that in the present state of knowledge it is impossible to recognize the gonococcus with absolute certainty, and to distinguish it from other micrococci to be found in vaginal secretions. In the last article, upon "the gonococcus in legal medicine," it is stated that in the authors' experience only one variety of micrococcus is found in the acute vulvitis of little girls; and this presents all the features of the gonococcus.

In conclusion, they feel justified in the statement that at the present time the question of the gonococcus is far from being solved with that complete certainty which forensic medicine requires, and believes that in no case is the expert authorized in affirming the blennorrhagic nature of a vulvitis based upon a bacteriological examination, no matter how complete.—*Journal of Cut. and Ven. Diseases.*

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**PRESENT STATUS OF BRAIN SURGERY.**—At the recent American Surgical Association, in Washington, Dr. D. Hayes Agnew, of Philadelphia, presented a paper with this title. Following are his conclusions :

1. That all fractures of the skull attended with depression, however slight, and entirely irrespective of symptoms, should, in view of the late after-effects, be subjected to the trephine.
2. That trephining for traumatic epilepsy promises only palliation at best.
3. That trephining for Jacksonian epilepsy is to be regarded as only affording temporary benefit.
4. That trephining for abscess, in view of the fact that all such cases left alone



almost invariably terminate fatally, is entirely proper, and that the earlier such operation is done the better. 5. That trephining for intra-cranial traumatic hemorrhage is both an imperative and highly promising operation. 6. That trephining for cephalalgia, or traumatic epilepsy (medical measures having failed), should be undertaken with every prospect of success. 7. That trephining for hydrocephalus is a useless operation. 8. That trephining for microcephalus, independent of athetosis, confers no credit upon surgery. 9. That it is more than probable that as our observations multiply the sphere of the trephine as a preliminary for the removal of brain tumors will be lessened rather than be amplified.

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**AN EXTREME CASE.**—At the meeting of the Obstetrical Society, Mr. M. Shield read a paper upon a case of extra-uterine gestation associated with sloughing of the abdominal wall and attempted extrusion of a matured and putrid fœtus near the umbilicus. The patient, a young married woman, a primipara, had been ill with fever, and for some months there had been a large abdominal tumor. Upon exploration, the uterus was found empty. Near the umbilicus there was a considerable ovoid opening with sloughing margins. Through this protruded a tumor somewhat larger than a cricket-ball; at its somewhat constricted base it was firmly grasped by the surrounding tissues; the tumor was black and offensive. The patient was placed under chloroform, and the opening enlarged downward, and a fœtus was extracted along with much fœtid fluid and gas, followed by bright blood. The placenta was deeply attached above and behind, and the sac appeared to be extra-peritoneal. The hæmorrhage was stopped by hot water irrigation. The placenta was removed piecemeal, further bleeding being prevented by packing with sponges. The patient made a good recovery.—*American Lancet, London Letter.*

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**DIAGNOSIS OF TUBERCULAR MENINGITIS IN CHILDREN.**—At a recent meeting of the American Pædiatric Association, Dr. W. P. Northrup read an interesting paper on this subject. He gave

four symptoms which, when they existed together, were to him convincing evidence of the disease—persistent vomiting, irregular pulse, irregular breathing and apathy; there were also other significant symptoms connected with the organs of special sense. Professor Jacobi agreed with Dr. Northrup in the importance of the persistent vomiting as a diagnostic sign; the vomiting is apt to be marked when the meninges of the base of the brain are the seat of the tubercular deposit; if the tubercular deposit is not marked in this region the vomiting is apt to be less pronounced or absent. Distinction must be made between the cerebral type of vomiting, which is projectile and not accompanied by nausea, and that which is merely reflex or of gastric origin. Dr. Northrup traced the infection in one of his reported cases to the use of tuberculous milk.—*American Journal Medical Sciences.*

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SCIATICA.—Concerning this disease, Dr. Eliot, New Haven, Connecticut, makes the following suggestions (*New York Medical Journal*):

1. A large proportion of cases of sciatica are neuritis, and not simply neuralgia.

2. Temporary relief of suffering should be secured by hypodermic injections of morphine and atropine, or of theine.

3. Among curative agents, salicylate of sodium and iodide of potassium are especially valuable—the former in acute, the latter in chronic cases.

4. Considerable benefit may often be derived from the administration of the more purely neurotic drugs—aconite, belladonna, and gelsemium, as:

R. Ext. belladon., fl. ʒss.

Ext. aconiti., fl. ʒiss.

Ext. gelsem., fl. ad ʒvi.

M. Sig.—Give six, seven or eight drops every four hours.

5. Cantharidal blisters are of great service in promoting the cure of the disease, when used in conjunction with appropriate internal treatment.

## ACUTE BRONCHITIS.—Dr. H. C. Wood:

℞. Potass. Nitrat..... 1 ounce.  
 Suc. limonis..... 2 fl. ounces.  
 Syr. ipeac..... ½ fl. ounce.  
 Syr..... 6 fl. ounces.

M. Sig.—A tablespoonful four to six times a day.

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HYDRASTIS CANADENSIS IN NIGHT SWEATS.—Dr. Cruse relates in the *All. Med. Zeitung* an observation made on the above drug. He employed hydrastis for a case of hæmoptysis and observed that night sweats did not come on as usual. Patient was in the last stage of phthisis. This led to his trying hydrastis for the night sweats themselves. He gave thirty minims of the fluid extract, and always with complete success. And what is more, the sweats kept off when the hydrastis had been omitted for three weeks. These results were confirmed by trials in a number of cases.—*Lancet Clinic*.

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ECZEMA OF THE FACE AND SCALP.—Crusts should first be softened with olive oil, and after they are removed the surface should be anointed with the following ointments :

℞. Ac. boric, 45 grains.  
 Zinc oxide, 75 grains.  
 Vaseline, } of each 450 grains.  
 Starch, }

Eliminate fatty materials from the diet, and combat habitual constipation with appropriate enemata.—*Medical News*.

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A DEATH under ether occurred in New York, September 9th. The patient was a man, fifty years of age, who was to be operated upon for removal of a tumor of the side. He was examined previous to the administration of the ether, and presented no symptoms of heart trouble.—*Med. Record*.

The Southern Surgical and Gynecological Association will meet in Richmond, Va., Nov. 10th, 11th and 12th.

Following is a partial list of papers to be read: The President's Annual Address, Louis S. McMurtry, M. D., Louisville, Ky.; Remarks on Systemic Infection from Gonorrhœa, Illustrated by Cases, Bedford Brown, M. D., Alexandria, Va.; The Rational Treatment of Peritonitis Based upon the Consideration of the Pathological Conditions Present, W. D. Haggard, M. D., Nashville, Tenn.; A Medico-Legal Aspect to Pelvic Inflammation, W. W. Potter, M. D., Buffalo, N. Y.; Complications in Pelvic Surgery, and How to Deal with Them, Joseph Price, M. D., Philadelphia, Pa.; Cholecystotomy—Report of Case—52 Gallstones and 10 Ounces of Pus Removed—Success, W. B. Rogers, M. D., Memphis, Tenn.; Some of the Complications of Psoas Abscess, J. McFadden Gaston, M. D., Atlanta, Ga.; Laparotomies Performed in the Past Year, Thomas Opie, M. D., Baltimore, Md.; Imperforation of the Rectum, Geo. Ben. Johnston, M. D., Richmond, Va.; A Case of Induced Abortion for the Relief of the Nausea, and Vomiting of Pregnancy, with Remarks, Christopher Tompkins, M. D., Richmond, Va.; The Principle of Drainage as Applied to Surgery of the Deep Urethra, F. W. McRae, M. D., Atlanta, Ga.; The Neuroses of the the Genito-Urinary System in the Male, Frank Lydston, M. D. Chicago, Ill.; Nephrectomy, with Report of Cases, Edwin Ricketts, M. D., Cincinnati, O.; Venomous Serpents of the United States, and the Treatment of Wounds Inflicted by Them, Paul B. Barringer, M. D., University of Virginia.; A Report of Some Additional Cases of External Perineal Urethrotomy without a Guide, J. Edwin Michael, M. D., Baltimore, Md.; Growth of Fibroid Tumors of the Uterus, after the Menopause, Jos. Taber Johnson, M. D., Washington, D. C.; The Part the Shoulders Play in the Production of Laceration of the Perineum, with Suggestions for its Prevention, W. D. Haggard, M. D., Nashville, Tenn.; The Pedicle in Hysterectomy; How Formed; Its Subsequent Behavior; Its Final Condition, I. S. Stone, Washington, D. C.; A Case of Pelvic Abscess, John Brownrigg, M. D., Columbus, Miss.; A Case of Cyst of the Mesentery, with Remarks, J. A. Goggans,

M. D., Alexander City, Ala.; The Female Urethra, K. P. Moore, M. D., Macon, Ga.; Medico-Legal Aspect of Intestinal Surgery, J. D. S. Davis, M. D., Birmingham, Ala.; Albuminuria; Its Relation to Surgical Operations, J. W. Long, M. D., Randleman, N. C.; Senile Gangrene, Frank Prince, M. D., Bessemer, Ala.; Hemorrhage *versus* Shock, W. L. Robinson, M. D., Danville, Va.; Treatment of Gallstone, with Report of Cases, W. E. B. Davis, M. D., Birmingham, Ala.; (Title of paper not determined), Hunter McGuire, M. D., Richmond, Va.; (Title of paper not determined), Duncan Eve, M. D., Nashville, Tenn.; (Title of paper not determined), A. V. L. Brokaw, M. D., St. Louis, Mo.; (Title of paper not determined), Chas. A. L. Reed, M. D., Cincinnati, O.; (Title of paper not determined), W. F. Westmoreland, M. D., Atlanta, Ga.

LOUIS S. McMURTRY, M. D., President.

W. E. B. DAVIS, M. D., Secretary.

#### MEMBERSHIP IN THE AMERICAN MEDICAL ASSOCIATION.—

This is obtainable, at any time, by a member of any State or local Medical Society which is entitled to send delegates to the Association. All that is necessary is for the applicant to write to the Treasurer of the Association, Dr. Richard J. Dunglison, Lock Box 1274, Philadelphia, Pa., sending him a certificate or statement that he is in good standing in his own Society, signed by the President and Secretary of said Society, with five dollars for annual dues. Attendance as a delegate at an annual meeting of the Association is not necessary in order to obtain membership. On receipt of the above amount the weekly *Journal* of the Association will be forwarded regularly.

DR. CHRISTOPHER JOHNSTON, one of the most prominent surgeons of Baltimore, died October 11th, in the sixty-ninth year of his age. He was, at the time of his death, Professor of Surgery in the University of Maryland.

## Book Reviews.

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**A CLINICAL TEXT-BOOK OF MEDICAL DIAGNOSIS FOR PHYSICIANS AND STUDENTS, BASED ON THE MOST RECENT METHODS OF EXAMINATION.** By Oswald Vierordt, M. D., Professor of Medicine at the University of Heidelberg. Formerly Privat-docent at the University of Leipzig; later Professor of Medicine and Director of the Medical Polyclinic at the University of Jena. Authorized translation from the second improved and enlarged edition. By Francis H. Stuart, A. M., M. D. With one hundred and seventy-eight illustrations, many of which are in colors. W. B. Saunders, Philadelphia, 1891.

It is with great pleasure that we present a notice of this superior book to our readers. From beginning to end it is filled with the latest and best diagnostic knowledge. Following the introduction come chapters on examination of patients, general examination, examination of respiratory apparatus, examination of the circulatory apparatus, examination of the digestive apparatus, examination of the urinary apparatus, and examination of the nervous system.

The topographical anatomy of each region is concisely presented in the text and clearly delineated in the illustrations. Bacteriology has received due notice by "a concise presentation of those peculiarities of the micro-organisms, whose recognition and discrimination are made possible by cultures and inoculation." "The illustrations of the most important micro-organisms are printed in colors."

Translator and publisher have done their work well. As a whole the book deserves our highest commendation. We heartily recommend it to both student and general practitioner as one of the very best works on medical diagnosis.

F. W. M.

**INTERNATIONAL CLINICS.** A Quarterly of Clinical Lectures, by Professors in the Medical Colleges of the United States, Great Britain and Canada. Edited by J. M. Keating, M. D., Philadelphia; J. P. C. Griffith, M. D., Philadelphia; J. Mitchell Bruce, M. D., London, and D. W. Finlay, M. D., London. Philadelphia, J. B. Lippincott Co.

The clinical lectures which will appear quarterly in this publication will occupy the entire subject of medicine and surgery. It is the publishers' purpose to make this periodical a complete post-graduate course of medical instruction, and as far as printed lectures can answer for personal observation and contact with patients, we doubt not that these volumes will be an excellent substitute. Among the contributors are the best names in American, Canadian and English medicine and surgery. The subjects are well chosen, and practical, and of great value and interest to the general physician. The lectures on Infantile Eczema, and Modern Methods in Surgical Operations, we may especially commend.

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**PRACTICAL PATHOLOGY AND MORBID HISTOLOGY.** By Heneage Gibbes, M. D., Professor of Pathology in the University of Michigan, etc. Philadelphia, Lea Bros. & Co.

We have not seen a more practical work on microscopical anatomy than this. Parts I and II, on Practical Pathology and Bacteriology, relate to the methods of microscopical examination of tissues and bacteria, and for the purposes designed these subjects are presented in a manner that leaves nothing to be desired.

In Part III, or Descriptive Pathology, the organic lesions of disease are concisely discussed. This portion is fully illustrated, not with diagrams, but with excellent photo-engravings. For those wishing a work of this sort, not able to obtain what is, of course, much better, namely, actual laboratory practice, we know of nothing better.

# THE ATLANTA AND MEDICAL SURGICAL JOURNAL.

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## TO CONTRIBUTORS.

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ATLANTA MEDICAL AND SURGICAL JOURNAL, Post-office box 431.

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## Original Communications.

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### THIRTY-TWO UNSELECTED ABDOMINAL SECTIONS WITH TABLES.\*

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By THOMAS OPIE, M. D.,

Professor of Gynecology College of Physicians and Surgeons of Baltimore,  
and Gynecologist to the Baltimore City Hospital.

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GENTLEMEN—It is with no little diffidence and apprehension that I offer this Society a paper which is the beaten track and the hackneyed theme of a narration of cases, especially since it has been made up little by little, as the fragments could be wrested from the busy activities of the practical doctor.

I do not come before you with the promise to present new, therefore interesting, facts. All of us might admit the paucity of facts, even in the great province of medicine, yet all are earnestly looking and longing for them. Every statement, propo-

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\*Read before the Southern Surgical and Gynecological Association, November, 1891.



sition or theory in any department of medicine, before it can be reckoned among settled facts, must be submitted to a calm judicial consideration, publicly and openly, before the bar of the medical profession.

In new fields the caution and deliberation of the profession is especially commendable. The experience of many observers is desired; full and free discussion is sought; extensive statistics are essential. In submitting this statement of a year's work in abdominal surgery, though it be small as compared with that of many operators, it is to be hoped that it will elicit a full and frank interchange of experience, and thereby help in some measure progress in this department of gynecological surgery.

In doing so I do not hesitate to say that every narrator of his personal experience should, when before the tribunal of the profession, feel that the withholding of a single error of omission or commission vitiates his confession. We want the truth, but more, we earnestly desire the whole truth.

Statistics framed in this spirit would be invaluable to the profession, and, therefore, to the human family. In other words "every man should be his own critic."

The accompanying tabulated statement embraces thirty-two abdominal sections made in the twelve months, beginning November 1, 1890, ending October 31, 1891.

This list does not include the whole number of laparotomies performed at the Baltimore City Hospital during the time stated, since this institution opens its doors to all operators of good professional standing who may see fit to attend and operate on such cases within its walls.

The writer had the misfortune to receive an attack of septic empoisonment on December 10, 1889, from the prick of a pedicle needle, while performing a laparotomy on a case of septic peritonitis. This report therefor represents his first year's work immediately following that interruption, which lasted over a year.

It has been said, in connection with this important and relatively new work, that there is "too much surgery." In answer to this charge I would say that this question can best be decided by surgeons.

"Everything is, by calm behest,  
Resigned to him who understands it best,  
But every wordy, theoretic leech  
Can teach the teacher how he ought to teach."

It is a sad state of things if we can say of any individual surgeon that he is not wiser at the end than at the beginning of his year's work. He can, however, no more than the physician, claim immunity from mistakes. If he be wise or skillful he will not be chargeable with repetitions of the same mistakes; thus he, as well as his future patients, will profit by his failures. Moreover, there is inevitably an error in judging the work in this or any other branch of medicine by the results of individual operators. The whole of a thing can never be accurately determined by any one of its parts.

The statistics in this new field are as yet comparatively small, and the facts are few. It is quite well established that the happenings incident to surgery will bear a very close relationship to each other in every one hundred cases. It is equally true that knowledge, calmness, deliberation, cleanliness and promptness in coping with emergencies constitute the differences between surgeons. A succinct definition for science is methodized knowledge, but something must be added to cover the work of the surgeon, viz., common sense and sound judgment. It is also true that with a skillful surgeon each one hundred cases in his own experience should be a success beyond its predecessor.

Would it not subserve a good purpose to adopt some uniformity in our mode of collecting statistics? It might be an improvement if all members of this Society would alike report their work in this department fully from one meeting to another, or at least upon some uniform plan. As it is, the statements are fragmentary and, therefore, not so valuable, since successful cases are given prominence and failures are apt to be overlooked. It is agreeable to recount our successful cases; it is a very severe test to confess our losses.

What there has been of error or detraction in my work I will, as frankly and as fully as I know how to do, place before you conspicuously in the early part of this statement, nor will I ask you to "hide the faults (you) I see."

## UNSELECTED CASES.

The operations were performed consecutively, as set forth in the accompanying table. They were:

Ovarian tumors.....	6
Chronic ovaritis.....	7
Fibroid tumors.....	4
Pyosalpinx.....	5
Retroflexion with adhesions and dysmenorrhœa....	3
Exploratory incisions.....	3
Extra-uterine pregnancy.....	1
Abscess of ovary.....	1
Cyst of broad ligament.....	1
Cystic degeneration of ovary.....	1
Total.....	32

Nine of these patients came to me through the dispensary connected with the college and were operated on in the amphitheatre before the whole class at the College of Physicians and Surgeons; the remainder, twenty-three, were operated on privately. Twenty-seven were white and five were colored.

## DEATHS.

The deaths were as follows :

Oöphorectomy for pyosalpinx.....	1
Shock from ovariectomy.....	1
Oöphorectomy for acute mania.....	1
Abdominal hysterectomy for fibro-cystic tumor....	1
Total.....	4

No attempt will be made to describe fully each individual case but the classification will admit of a separate discussion of the various classes of disease or operations and enable the writer to select and lay before the Association what seems of special interest.

In such a report as this, the deaths are commonly regarded as stigma; nevertheless they are usually instructive. I must give a

full account of my stewardship, and consequently trespass upon your time, with the details of each one of them.

No. 7, colored servant, single, had received dispensary treatment for several months for gonorrhœa. The diagnosis was made out correctly, as the sequel proved, as gonorrhœal pyosalpinx. The urgent necessity for surgical interference was impressed upon the patient, but the operation was long deferred. On the 5th of February, '91, a laparotomy was performed. Both ovaries and both tubes were matted together and adherent to the intestines in the posterior cul-de-sac. They were with difficulty removed. The left tube burst in detaching it, and its virulent contents were discharged into the peritoneal cavity. The pus was easily and freely squeezed out of both tubes, after removal. The abdomen was flushed out. Alarming hemorrhage ensued from the denuded surfaces of the cul-de-sac which was arrested by packing it firmly with iodoform gauze. This was removed in six hours. Her temperature rose to 101 degrees during the night, and reached 103 degrees the next day; pulse 130. She died on the third day of septic peritonitis.

*Post Mortem:* Flaky lymph and pus over intestines. No fluid in abdomen. Ligatures were holding securely.

CASE 10.—W., age 50, married; visited me at the hospital about February, '91 received an opinion that she had an ovarian tumor which was fully developed and should be removed at once. This advice was disregarded. She returned home and remained there until about six or seven weeks later, when a letter to her physician impelled her to come on for the much needed surgical treatment. She was admitted on the 16th of March and operated on on the 19th. Her condition was bad. Her temperature was 100, and pulse rapid. Her abdomen was very sore under palpation. The colloid contents and the solid elements of the tumor weighed over twenty pounds. The whole abdominal wall seemed ablaze with inflammation; the intestines were adherent largely to the tumor and matted together. The contents of tumor would not run, but had to be scraped out piecemeal by the hand. She was profoundly shocked; hypoderms of whiskey were given freely; milk, beef tea and whiskey were

administered per rectum ; though retained, they were of no avail. Death ensued at 3 A. M., I think from surgical and chloroform shock.

*Post mortem by Prof. Kierle:* No blood in abdomen whatever ; abdominal cavity perfectly dry. Ligatures tightly adherent to parts. Organs healthy. Died of shock.

CASE 18.—W., age 18, single, family history good. Had had periodical attacks of mania. The first attack came on simultaneously with her menstrual flow at 15 years of age. Her menstruation was always accompanied by severe pain. Six months ago she had so severe an attack of mania, that she was forced to go to an insane asylum. On the third day after the operation mania set in ; she could not be kept in bed. It was impossible to keep her bandage on. She grew more and more violent and died January 23, 1891—thirteen days after the operation.

*Post mortem by Prof. Kierle:* Complete *post mortem* not allowed. Kidneys markedly congested. No fluid in abdomen. Lungs congested. Brain not examined ; probable cause of death here.

No. 32.—W. M., white, married when 21 years of age ; sixteen years ago ; had three children and one miscarriage.

Five years ago noticed tumor in her abdomen, which gradually grew larger and was said to be an ovarian cystoma. She suffered from hemorrhages very often. They were profuse in character and at irregular intervals. On examination a tumor as large as a man's head was realized in the abdomen. The uterine probe ran up into it three-fourths of its length. An abdominal incision was made about eight inches long ; the tumor was lifted out of abdomen and secured by Baeker Brown's clamp. The bleeding was readily controlled and the peritoneal cavity flushed. The abdominal wall was closed with silk-worm gut and the stump secured at the lower angle of the wound. Though severely shocked she rallied well. The mass comprising the fibroid, womb, ovaries and tubes weighed ten pounds.

The patient did well for three or four days, but after this her pulse and temperature began to rise, and she died on the seventh day of septic peritonitis.

*Post mortem by Prof. N. G. Kierle:* Wound had entirely healed up; the clamp was tightly holding the stump. Abdomen contained two ounces of bloody fluid. The intestines were adherent and covered with inflammatory lymph. Kidneys soft and fatty; liver fatty. Death from septic peritonitis.

## EXPLORATORY LAPAROTOMY.

No. 4.—Age 46; operated on January 5th, 1891. The exploration revealed malignant degeneration of the left ovary, with cancerous cysts studding the peritoneum and intestines. A large amount of abdominal fluid was removed. The cavity was thoroughly flushed and the walls closed. Patient returned home in three weeks greatly improved. It must needs have been temporary.

No. 22.—Age 25, married, sterile. Operated August 26th, 1891. A large malignant growth was found in the left side involving the corresponding ovary and the liver. Patient had icterus at the time of operation. Stitches removed on the eighth day. She improved rapidly and returned to her home in good spirits.

M. O., operation, September 26th, 1891; age 33, widow; had two children and one miscarriage during wedlock. Performed criminal abortion with a tortoise shell bonnet pin. On admission a digital examination was made. The pelvis was blocked with exudates. In the center of the post cul-de-sac was a boggy point, the field all around solid to the touch. Percussion and palpation indicated the extension of the inflammation and effusion high up on the left side of the abdomen. The temperature in the mornings was about 101 degrees; in the evenings about 102 ½ to 103 degrees.

An exploratory incision was decided upon, and made in the median line. It was impossible to explore the pelvis; the strong resistant adhesions and exudation was an effectual stay law. A large amount of bloody serum was flushed out. The temperature at the time of operation, 102 degrees, began to decline at once; the effusion was gradually absorbed and at the end of three weeks there was no sign of the pelvic trouble. Drainage was not used in any one of the three cases.

The number of these cases is too small to prove anything, but they are suggestive and add to already strong testimony which is recorded, that a laparotomy done in thoroughly aseptic manner is a warrantable resort, when the indications are threatening and the diagnosis doubtful.

#### OVARIAN TUMORS.

The six cases of ovariectomy made good recoveries with the exception of No. 10, in which there was realized extensive peritonitis on opening the abdomen. This case is reported among the deaths.

No. 2.—W., single, age 38, was an interesting case, since in addition to the cystoma of the right ovary, which contained two and a half gallons of fluid, there was on the left side a dermoid cyst the size of a child's head. The contents consisted of bone, hair, etc. The pedicle of this tumor was four inches wide, hence there was some difficulty in constricting it efficiently, even in sections. This patient, strange to say, menstruated regularly up to August 25th last, within three months of the time of operation. She suffered from attacks of mental aberration during a year prior to the operation. Excellent recovery ensued both mentally and physically, which has been maintained without interruption from the time of the operation up to this date.

No. 21.—W., single, age 16. Her abdomen approximated the size of a woman's at full term, before the operation. She and her friends noticed the enlargement of her abdomen for the first time four years ago, when she was twelve years of age. It is fair to conjecture that it had filled the pelvis and like the pregnant uterus had developed into the abdominal cavity at that time. If there is a parallel between the nutritive growths in these two conditions, this tumor must have started at a very early age, possibly when she was eight or ten years old. Her first menstruation was in January last, and it recurred irregularly afterwards. She bore the operation and the subsequent treatment with the greatest fortitude and made an excellent recovery.

The other four cases of ovarian tumor presented nothing of special interest, save their complete and permanent recovery.

## CHRONIC OVARITIS.

In this class there were six. Among them was case No. 17, single, age 20. She began to menstruate at 15. Her first epileptiform spasm began coincidentally with this event. From that time up to the time of the operation, she had these attacks both during the interim and at the time of the menses. The attacks were more severe just preceding the establishment of the flow. They were attended by convulsive movements of a pronounced character, followed by a period of stupor or sleep lasting fifteen or twenty minutes. At other times they were caused by overtax, by mental worry or excitement. The intermenstrual spasms were attended by slight twitchings and a short sleep. Her friends, prior to seeking relief by oöphorectomy, had spent quite a fortune in their efforts to cure her, having had her under the treatment of some of the most eminent neurologists in New York. Electricity, massage, drugs, all in turn proved unavailing. No difficulties arose in the operation. A few days after the operation she had several spasms, but no harm ensued from them. Convalescence was uninterrupted and rapid. She spent several weeks at the seashore and paid me a visit on her return home. The young lady had gained notably in weight and strength, but the intermenstrual form of the attacks still recurred. At this writing I am unable to state her condition.

CASE 18.—White, single, 18 years of age, was an interesting case of this class, who had an attack of acute mania at the first menstrual flow. Six months ago she had a recurrence of insanity, and was sent to an insane asylum. Oöphorectomy was followed by acute mania. She was uncontrollable. Death ensued from sepsis. The case has already been reported in this paper under the caption of the deaths.

CASE 12.—White, single, age 21. Had always been sick since childhood; had been for years subject to recurrent attacks of follicular tonsillitis. Her menses were established at 17; about that time she had a severe attack of typhoid fever. For six months prior to the operation of oöphorectomy she had been bedridden. She was hopeless, dyspeptic and anæmic in the ex-



treme degree. Her neuralgic headaches and ovarian pains were intolerable at each menstrual epoch. She readily accepted the proposal as to removal of the ovaries. The operation was borne courageously, and her convalescence was uninterruptedly good. Upon her return to her home in Baltimore she relapsed into her former despondent condition. She has not fulfilled my expectations as to complete cure, though she has improved physically.

No. 14.—Age 23, white, single. Was healthy until 13, when menstruation began. At first the recurrences of it were painless and regular. An interruption of four months occurred and dysmenorrhœa, menorrhagia and ill health followed. Tormented by her physical pains and disqualification and her inability to support her aged parents, she sought oöphorectomy as a last resort. It has brought about excellent health and capabilities.

No. 16.—White, aged 22. S., unlike the preceding case, had led a life of luxury and ease. Her dysmenorrhœal pains in defecation and general depreciation in health during five years caused her family to seek the removal of the ovaries. Perfect satisfaction as to health, cheerfulness and comfort has come both to her and her friends.

No. 27.—Age 39, operation October 8th, colored, a washer-woman, widow. Had one full term child and one miscarriage. This patient was operated on by me one year ago for a deep laceration of the cervix. While the parts healed well, she was not benefited as regards her distressing and disqualifying dysmenorrhœa. The appendages were removed. She is still in the hospital. All the indications betoken a happy issue out of her afflictions.

It is noteworthy that five out of six of these cases of chronic ovaritis were single, and that their ages range from 18 to 23 years.

#### PYOSALPINX.

The five cases under this heading all made good recoveries was a very unpromising one. Both ovaries and tubes were packed in one conglomerate mass in the posterior cul-de-sac; one of the tubes ruptured on removal, causing septi-

cæmia. It is interesting to relate, as bearing on the etiology of this case, that every one of these cases was undoubtedly gonorrhœal in origin.

Two had been under treatment in our dispensary by Dr. W. S. Gardner, and the other three were ladies who were innocent victims to the viciousness of their husbands. I prescribed for one of the males a short time prior to marriage for gonorrhœa, and was greatly astonished, not long after that event, to find him with a bride whom he had infected by the same disease. Six months later the uterine appendages were removed. The other two confessed to having transmitted it to their wives. One of the cases was an extremely critical one, since a pus tube had burst and discharged through the rectum three months prior to the operation. From that date to the operation the lady was disqualified for any household duty, though she had around her a large family. When operated on, six months ago, she weighed 130 pounds; she now weighs 160 pounds, her weight when in former good health.

#### FIBROID TUMORS.

Two abdominal hysterectomies were performed for fibro-cystic degeneration of the uterus. The first was :

No. 11.—The abdominal incision was fourteen and a half inches long from the sternum to the pubis. The tumor weighed twenty pounds. Its vertical circumference measured twenty-three and a half inches, and its transverse circumference twenty-two and three-fourths. There was, in view of the very large pedicle, considerable difficulty in securing her against hemorrhage; hence the intra-abdominal method of treatment would most likely have failed had it been done. A full description of this case has already been published in the proceedings of the A. M. A. of 1891. The patient was unburdened and health is now being enjoyed.

The second was a case of supra-vaginal hysterectomy for a fibro-cystic tumor of the uterus. This has been described.

The third case of fibroids gave the following history: Her first intimation of a tumor was October 18, 1890. While playing on the piano she had a rush of blood which filled a chamber. This

was the time of her menstrual flow. She bled alarmingly at each menstruation. Prior to operation she had bled continuously for a month. Diagnosis was intramural fibroids, chiefly occupying the posterior wall. The pelvis was well filled by the tumor. While I hoped to find the ovaries, due preparation was made for a hysterectomy. They were happily in front and were removed. Not a drop of blood has appeared since the operation. She made a good recovery.

CASE 5 was one of sub-peritoneal fibroids. The patient had been bedridden for six months, though sick and disqualified for all the duties of a wife for years. The uterus was retroflexed by a fibroma, the size of a hen's egg, situated on the upper posterior part of the fundus. In addition to this, there was a small intramural fibroid, the size of a filbert, located on the posterior wall, at the junction of the body and neck. Myomectomy was done, and both ovaries and tubes were removed. She has made a good recovery.

#### HYSTERRORRHAPHY.

In two cases, No. 1 and No. 25, hysterorrhaphy was performed, after the removal of the appendages, for retroflexion of the uterus with chronic ovaritis and dysmenorrhœa.

The operation by suturing through the anterior uterine wall may well be considered obsolete. The first case I performed on 13th November last, suturing through the stump of the uterine appendages, without scraping or otherwise injuring the uterine wall. The outer parts of the sutures were cut off at the end of two weeks, and the remaining parts allowed to fall back into the abdomen.

In the second case, No. 25, the sutures were simply made to pierce (without tying) the ovarian ligament and brought through the abdominal wall opposite their respective insertions about one and one-half inches from the incision, and tied over a bridge of skin one-half inch wide. In two weeks they were removed by cutting one side and drawing them out entirely.

Both cases, when discharged, were in excellent condition. The uterus, in each case, was well secured in its rectified position, as

attested by several competent examiners. Further time is necessary to establish the permanency and value of these operations.

#### CYSTIC DEGENERATION OF OVARY, COMPLICATED BY PREGNANCY.

No. 23, M., 23 years old, has had no full term children, but three miscarriages during the first third of gestation. Patient had been subjected to considerable local treatment without avail. Her present trouble with the left ovary had been recognized during the past three years. The possibility of pregnancy was broached, but her attending physician said he had lately been making intra-uterine applications, and hence was confident she could not be pregnant.

On opening the abdomen, the diseased ovary was readily verified, but the uterus was unusually large and the cervix was dilated with parallel bar dilator, so as to explore its contents. A fœtus of six weeks was withdrawn; the ovaries were removed. The subsequent history of the case was uneventful save that recovery was rapid and complete. The ovary on left side was represented in the thickened portion of the wall of a cyst the size of a walnut.

#### EXTRA-UTERINE PREGNANCY IN A DOUBLE UTERUS. REMOVAL OF SAC AND THE REMAINING OVARY.

No. 30, age 32, had been married fifteen years, but was without offspring. Since girlhood she had been regular with menstruation. For four months past her menstruation had been scanty and irregular and her general health miserable. One month prior to the operation she was compelled to go to bed. When the patient was first examined, in consultation with Dr. Wm. Gombel, of Baltimore, her attending physician, there was a hard resistant mass occupying the left side of the pelvis, pressing upon the rectum and causing intolerable agony. Laparotomy was determined upon. A large encysted mass, the size of two fists, occupied the posterior and lateral regions of the pelvic basin, pushing the double uterus to the opposite side. At the outset, in enucleating it, the blood contents escaped, the sac was shelled out and the pedicle ligatured. The right ovary was re-

moved. The abdomen was flushed, the drainage tube inserted and the abdomen closed.

The double uterus was realized by sight as well as touch, it having been held up in the incision for a satisfactory recognition by all present. There were two distinct funduses with a deep sulcus between them. The cervix was single. The drainage tube was taken out in twenty-four hours. The patient, during about ten days, although doing well physically, had an attack of mania. Providentially, she was at no time unmanageable, though she was watched with the most assiduous attention by her nurse. She entertained two vagaries, but aside from them, was sane and logical. One was the constant dread that she was to be operated on by the doctor again, and when either of her attendants entered the room she was frantic with fright. The other departure was that she could hear her family talking in the next room. She would answer their supposed questions and plead pitifully that they be admitted. She is now perfectly sane, has gotten well of her stitch abscess, which followed the drain tube and is out of harm's way. An examination of the tissue of the sac showed it to be placental.

#### STITCH ABSCESS.

This complication occurred nine times, a much larger number relatively than I have seen recorded heretofore; while no case proved disastrous, several were exceedingly annoying in delaying patients in hospital. They occur most frequently in cases where the drain tube has been used. The early opening of abdominal dressings, for any purpose, favors their occurrence. When the dressings remained intact for seven days there seemed to be greatest immunity from the stitch abscess. Dr. Welch says, "A coccus, which may appropriately be called the staphylococcus epidermis albus, is a nearly, if not quite constant inhabitant of the epidermis, lying both superficially and also deeper than can be reached by present methods of disinfection of the skin. The coccus is found frequently in aseptic wounds. It may be the cause of disturbances, usually of a relatively slight degree, in the healing of the wound, especially when drainage

tubes are inserted. It is the most common cause of stitch abscesses in wounds treated aseptically and anti-septically."

#### DRAINAGE IN ABDOMINAL SURGERY.

Drainage was resorted to in but three cases during the year.

CASE 2, ovarian and dermoid cyst, had a drainage tube in five or six days, and I am convinced it retarded her convalescence.

No. 28, extra-uterine pregnancy, had a tube in less than twenty-four hours. If I may judge of the necessity for it by the quantity or quality of the discharge through it, I should say it did no good. A small superficial abscess at the entrance of the tube followed its withdrawal.

No. 32, ovarian abscess, had a drain tube in about twenty-four hours. An abscess occurred at the site of its entrance. The quart of pus, which was sacculated in this case, was removed without an atomic part of it touching the peritoneum or the wounded parts, otherwise her fate would have been sealed, as was the case in No. 7, where the pus tube burst and death ensued on the third day of peritonitis. Even in such a case as the latter, the most we could do would be to thoroughly flush out the abdomen.

I am of the opinion that there is even too much flushing done; it is but seldom called for. A plentiful supply of fine, properly prepared elephant ear sponges will do away with flushings in most cases and remove the necessity for drainage. They are efficient helps in keeping the abdomen free from infection. They can be utilized in keeping back the intestines, in occupying the cul-de-sac, in positions below the pedicle, in taking up blood or secretions, in staunching hemorrhage, in separating adhesions, in protecting the intestines while closing the abdomen. The assiduous personal attention of certain workers using the drain tubes has caused them to escape the disasters which have befallen the less careful and less skillful surgeons.

Nature's plan for curing the unsightly rents the surgeon makes when he opens the abdominal cavity is to seal hermetically the sacred cavity of the peritoneum in twenty-four hours. This kindly and providentially comports with its sensitiveness and its fitness for the cultivation of germs of disease. Does not this

prompt sealing of the peritoneum speak with unmistakable logic to the point of striving hard for an aseptic operation and for securing immediate and absolute closure ?

The oft-repeated removal of the dressing of the patulous drainage tube must of necessity be a very great danger ; surely it favors decomposition and invites germs. All surgeons are aware that after an anæsthetic, restlessness and jactitations are not wholly restrainable. It is easy to conceive how physical injury may accrue to the patient during this critical time from these not at all innocent, yet smooth, glass tubes.

I believe drainage is doing more harm than good and, therefore, ought to be abandoned by the abdominal surgeon.

There is a dual personality as well as power concerned in all surgical work. The one is the surgeon, who skillfully meets and disposes of the crisis in the more mechanical part of the work and, therefore, receives the plaudits of the multitude ; the other is the influence behind the throne, more potent than the throne itself, which reaches beyond the eye, the touch and the knife. I scarcely need say it is the modest, yet oft-despised, laboratory physician who is teaching us the hidden leaven of disease. Let us give him grateful recognition, for the pivotal facts and secret springs in recent surgical success. When he says bruised tissue is a paragon field for the cultivation of infectious germs, let us heed the warning and cast aside the drainage tube.

Dr. Park says as to drainage: "Views and practices concerning drainage have materially changed even since the antiseptic era began. Our predecessors drained to permit escape of pus, which they knew would form. Until lately we have drained in order to prevent its formation. We seem now to be on the eve of an era when we need to drain but little or not at all. We resort to drainage now only of necessity, in septic or infected cases. In other cases we drain mainly from habit, or from fear. Indeed, when we start afresh, as it were, without previous infection, the practice of drainage is a confession of fear or of weakness, both of which are alike unscientific and unfortunate. It even seems to me that in many cases where all other aseptic requirements have been met, we do much more harm than good by the use of drains."

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TABLE OF ABDOMINAL SECTIONS AT BALTI-  
MORE CITY HOSPITAL,

By THOMAS OPIE, M. D.

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## ABDOMINAL SECTIONS.

No. and Color.	Name.	Age.	Date.	Single.	Married.	Children.	Miscarried.	Disease.
1 W.	H. T.	30	Nov. 13, 1890.	.....	M.	5	.....	Retroflexion dysmenorrhœa.
2 W.	W. E.	38	Nov. 24, 1890.	S.	.....	.....	.....	Ovarian tumor and dermoid cyst.
3 W.	H. L.	37	Nov. 28, 1890.	S.	.....	.....	.....	Chronic ovaritis dysmenorrhœa and hysteria.
4 W.	B. C.	46	Jan. 4, 1891.	.....	M.	.....	.....	Cancer of the ovary.
5 W.	P. N.	47	Jan. 9, 1891.	.. . . .	M.	.....	.....	Subperitoneal fibroids.
6 W.	R. S.	32	Jan. 28, 1891.	.....	M.	5	.....	Gonorrhœal pyosalpinx.
• 7 B.	S. J.	21	Feb. 2, 1891.	S.	.....	.....	.....	Gonorrhœal double pyosalpinx. Extensive adhesions.
8 W.	S. A.	22	Feb. 9, 1891.	.....	M.	.....	.....	Gonorrhœal salpingitis, chronic ovaritis.
9 W.	S. B.	23	Feb. 22, 1891.	.....	Widow.	.....	.....	Ovarian tumor.
10 W.	W. S.	50	March 19, 1891.	.....	M.	.....	.....	Ovarian tumor. Peritonitis.

## BALTIMORE CITY HOSPITAL.

Operation.	Drain.	Complications.	Rec'd.	Died.	Remarks.
Removal of both ovaries. Hysterorrhaphy.	No.	Stitch abscess.	R.	.....	Examination before leaving the hospital showed the displacement to have been corrected. Health restored.
Extirpation of both tumors.	Yes.	.....	R.	.....	Right ovary distended with 2½ gallons fluid. Nearly its entire surface was adherent to abdominal wall. On the left side was a dermoid cyst the size of a child's head, the pedicle of which was four inches wide. Recovery complete.
Removal of both ovaries.	No.	.....	R.	.....	A working woman totally disabled from making a living; was anæmic, subject to dysmenorrhœal pains, vertigo and fainting fits. Health has been entirely restored.
Exploratory laparotomy.	No.	.....	R.	.....	Large cancerous cysts studded the peritoneum and intestines. Ovaries had undergone malignant degeneration. Abdominal fluid was removed, the cavity flushed. Patient returned home in three weeks much improved.
Myomectomy, oophorectomy.	No.	.....	R.	.....	Had been bedridden for 6 months, though sick for years. Uterus was retroflexed by a fibroid the size of a hen's egg, on the upper posterior aspect of the fundus. This was removed. A small fibroid located on posterior wall of uterus. Hence oophorectomy. Result permanently good.
Removal of both ovaries and tubes.	No.	.....	R.	.....	On the fourth day after operation menstruation seemed to be at hand and lasted four days. Made an excellent recovery and has seen no show since.
Removal of both ovaries and tubes.	Yes.	A pus tube burst; hemorrhage was very great.	.....	D.	Patient died of sepsis on the third day. The whole of Douglas' cul-de-sac was denuded and from this surface copious hemorrhage ensued. Bleeding was arrested by packing with iodoform gauze.
Removal of both ovaries and tubes.	No.	.....	R.	.....	Anæmia most pronounced; complexion waxy; general health very bad, so much so as to render doubtful the advisability of operation. The gravity of the case stated to the friends. The results most satisfactory.
Removal of tumor and the other ovary.	No.	Stitch abscess.	R.	.....	Patient noticed her abdomen was growing larger when she was twelve. She had her menses last winter several times, but the flow was scanty. Her periods were irregular. Had an uninterrupted and rapid recovery.
Exploratory laparotomy.	No.	.....	R.	.....	Found a large cancerous mass in the left side involving the liver as well as ovary. Closed the abdomen. Recovered sufficiently to go home.

## ABDOMINAL SECTIONS.

No. and Color.	Name.	Age.	Date.	Single.	Married.	Children.	Miscarried.	Disease.
11 W.	T. V. L.	48	April 20, 1891.	.....	M.	.....	.....	Fibro-cystic tumor of uterus.
12 W.	H. J.	21	April 21, 1891.	S.	.....	.....	.....	Chronic ovaritis, dysmenorrhœa.
13 W.	S. M.	35	April 26, 1891.	.....	M.	5	.....	Uterine retroflexion. Abscess involving right tube and ovary discharged through rectum. Painful mass on right side of pelvis.
14 W.	A. B.	23	May 9, 1891.	S.	.....	.....	.....	Dysmenorrhœa, anemia, metrorrhagia.
15 W.	S. E.	28	May 11, 1891.	.....	M.	3	.....	Ovarian tumor of right ovary, left ovary had a cyst in it containing 10 ounces fluid.
16 W.	W. A.	22	May 20, 1891.	S.	.....	.....	.....	Chronic ovaritis, dysmenorrhœa, anemia.
17 W.	S. K.	20	June 3, 1891.	S.	.....	.....	.....	Epileptiform spasms, dysmenorrhœa.
18 W.	V. M.	18	June 18, 1891.	S.	.....	.....	.....	Acute mania, dysmenorrhœa.
19 W.	S. M. L.	25	July 4, 1891.	.....	M.	.....	.....	Traumatic peritonitis, retroflexion, displaced and diseased ovary.

## BALTIMORE CITY HOSPITAL.

Operation.	Drain.	Complications.	Rec'd.	Died.	Remarks.
Removal of both ovaries and a fetus of six weeks.	No.	Pregnancy	R.	.....	Examination disclosed enlarged and cystic ovaries. Her physician had probed the uterus and was satisfied she could not be pregnant. She had had three miscarriages in the first-third of gestation. Determined after conference to remove the fetus and continue operation. Result excellent.
Removal of the ovaries.	No.	Stitch abscess.	R.	.....	Had expected to do a hysterectomy, as uterus was large and it was unlikely that the ovaries could be reached, but both were in front and easily removed. Patient had some metropéritonitis for several days, but made an excellent recovery.
Removal of both ovaries, including the cellulitic mass involving the right ovary.	No.	.....	R.	.....	Hemorrhage readily controlled. Blood removed thoroughly by sponges, which had been packed in cul-de-sac. No drainage, no flushing. Temperature did not rise above 100°. Stitches removed on tenth day. Recovery rapid. In five months has increased in weight from 130 lbs., at time of operation, to 160 lbs. Health excellent.
Removal of both ovaries and tubes.	No.	.....	R.	.....	A factory hand who had been compelled to quit work on account of ill health, has been able to resume work, is in good health and spirits.
Removal of tumor and the other.	No.	Stitch abscess.	R.	.....	Made an excellent recovery except as to the delay from the stitch abscess.
Removal of both ovaries and tubes.	No.	Stitch abscess.	R.	.....	Elevation of temperature combated successfully by salines. Two stitches removed on fifth day and the others on the seventh day, because of redness around them. Superficial suppuration continued two weeks; healing rapid. Thorough recovery.
Removal of both ovaries and tubes.	No.	.....	R.	.....	Menstruation begun at fifteen, since then had been at every recurrence subject to fits. A number of distinguished nerve specialists in New York and elsewhere had treated her. Massage, electricity, drugs, all alike failed. Recovery from operation excellent. Cure incomplete.
Removal of both ovaries and tubes.	No.	.....	.....	D.	Had periodical attacks of mania with menses since first appearance at fifteen. Six months ago was in an insane asylum. A few days after operation, acute mania set in. She died the eleventh day after operation.
Removal of both ovaries and tubes.	No.	Cystitis.	R.	.....	Uterus retroflexed and bound by adhesions in its malposition. Had cystitis. Was always in pain. Menstruation painful and irregular. Cause: A fall when fourteen years old. Recovery complete.

## ABDOMINAL SECTIONS.

No. and Color.	Name.	Age.	Date.	Single.	Married.	Children.	Miscarried.	Disease.
20 B.	D. K.	42	July 18, 1891.	S.	.....	.....	.....	Ovarian tumor.
21 W.	W. A. S.	16	July 23, 1891.	S.	.....	.....	.....	Ovarian tumor.
22 W.	L. C.	25	Sept. 1, 1891.	.....	M.	.....	.....	Cancer of left ovary involving the intestines.
23 W.	W. E.	23	Sept. 2, 1891.	.....	M.	.....	.....	Both ovaries cystic. The left mass of cysts displaced in posterior cul-de-sac and adherent.
24 B.	R. R.	27	Sept. 9, 1891.	S.	.....	.....	.....	Intramural fibroids. Dysmenorrhœa. menorrhagia alarming extent.
25 W.	R. A.	33	Sept. 24, 1891.	.....	M.	2	1	Retroflexion, prolapsed ovaries, dysmenorrhœa.
26 W.	M. O.	33	Sept. 26, 1891.	.....	.....	.....	.....	Peritonitis, hæmatocele, abortion.
27 B.	C. M.	39	Oct. 8, 1891.	.....	Widow.	1	1	Chronic ovaritis, dysmenorrhœa.
28 W.	S. M. L.	25	Oct. 18, 1891.	.....	M.	.....	.....	Cyst in broad ligament

## BALTIMORE CITY HOSPITAL.

Operation.	Drain.	Complications.	Rec'd.	Died.	Remarks.
Removal of tumor and the other ovary.	No.	Stitch abscess	R.	.....	Patient noticed the growth six years ago, but did not know what it was. It was claimed by her that menopause came on at thirty-six, and growth was more rapid the last three years. When she left hospital the abscess had not completely healed. Recovery is complete.
Removal of tumor and other ovary.	No.	Slight stitch abscess.	R.	.....	Made a complete recovery. Have seen her lately in good health. Has resumed her wonted weight and vigor.
Removal of tumor and other ovary.	No.	.....	.....	D.	Patient called six weeks before operation and was, in view of the great abdominal development, advised to accept immediate operation. When she arrived she was suffering with peritonitis. Death took place two hours after the operation, from surgical and chloroform shock.
Abdominal hysterectomy.	No.	.....	R.	.....	Incision $10\frac{1}{2}$ inches. Tumor weighed 20 pounds, its vertical circumference was $23\frac{1}{2}$ inches and its transverse $22\frac{3}{4}$ inches. Treated stump extra-peritoneally. Temperature did not reach beyond $99^{\circ}$ , nor pulse below 30. Recovery was uninterrupted and complete.
Removal of both ovaries	No.	.....	R.	.....	Had been bedridden for over six months. Had been a sufferer with dysmenorrhœa since seventeen, when her menstruation began. She gained in weight and was cheerful for a while, but relapsed into the same neurotic state as before operation. Improved physically, not mentally.
Oophorectomy. Hysterorrhaphy.	No.	Stitch abscess.	R.	.....	Has suffered for years with retroflexion and prolapse of ovary; was disabled for all duty. Removed both ovaries and stitched the uterus to the abdominal wall. Made a good recovery.
Exploratory laparotomy	No.	.....	R.	.....	Time of operation, temperature $102^{\circ}$ . It began to fall at once. In three weeks the exudates were removed. Has made a perfect recovery.
Oophorectomy.	No.	.....	R.	.....	Nothing worthy of comment save relief from pain and promise of complete recovery.
Laparotomy for removal of cyst.	No.	.....	R.	.....	Same case was operated on July 4, 1891. Cyst of broad ligament containing serum removed. Entire relief from pain. Recovery uninterrupted. Is now sitting up.

## ABDOMINAL SECTIONS.

No. and o or.	Name.	Age.	Date.	Single.	Married.	Chil- dren.	Miscar- ried.	Disease
29 W.	G. L.	32	Oct. 18, 1891.	.....	M.	.....	1	Extra-uterine preg- nancy.
30 W.	B. L.	37	Oct. 15, 1891.	.....	M.	4	1	Pyosalpinx.
31 B.	B. M.	32	Oct. 17, 1891.	.....	M.	.....	1	Ovarian abscess.
32	W. M.	37	Oct. 29, 1891.	.....	M.	3	.....	Fibro-cystic tumor of uterus.

## BALTIMORE CITY HOSPITAL.

Operation.	Drain.	Complica- tions.	Rec'd.	Died.	Remarks.
Laparotomy, removal of sac, with placenta and both ovaries.	Yes.	Mania of a mild type.	R.	.....	Four months had scanty, irreg- ular and painful menstruation. She was compelled to go to bed one month ago. On opening ab- domen a large sac in left iliac region strongly adherent to sur- rounding structures, involving tube and ovary. Microscopic examination showed placental tissue. Drain tube used twenty- four hours. Recovered.
Removal of both ovaries and both tubes.	No.	.....	R.	.....	Had a clear history of gonor- rhœa; was under dispensary treatment for three months. Flushing was used; no drainage. Recovered without unfavorable conditions.
Extirpation of abscess sac and other ovary and tube.	Yes.	Stitch ab- scess.	R.	.....	Sac filled the pelvis nearly to the umbilicus, was at every point adherent to uterus, intestines or abdominal wall—was enucleated by the hands rather than the knife. Drainage tube used twenty-four hours. Her recov- ery is to be regarded as phe- nomenal.
Abdominal hysterecto- my.	No.	.....	.....	D.	Tumor began to show five years ago. Since then has been suf- fering profuse hemorrhages. Was supposed to be an ovarian tumor. Got through operation well. The stump secured by the Baker-Brown clamp. No bleed- ing. About the fifth day tem- perature up to 103°; pulse 150. Death took place on the seventh day from peritonitis.



## OPHTHALMIA NEONATORUM.

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By FRANK TRESTER SMITH, A. M., M. D.,  
Prof. of Diseases of the Eye, Chattanooga Medical College, Chattanooga, Tenn.

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The importance of the subject is suggested by three facts:

1st. Of the number of blind in our asylums a large per cent. of the blindness is produced by this cause.

2d. The increase in the number of blind in the United States has been increasing in a greater ratio than the population.

3d. Blindness from this cause is entirely preventable.

So important is this subject regarded in Europe that many of those countries have special legislation on the subject. This legislation generally provides that at the time the birth is registered a card is given the mother cautioning her about the danger of any discharge from the eye. Some laws require the midwives to report any redness or discharge.

To Dr. Howe, of New York, we are indebted for calling attention to the frequency of blindness and the facts concerning its increase.

Since the introduction of Credé's method the percentage of cases has been materially decreased in large lying-in hospitals. In his own service from 7.85 to .31 per cent.

The cause is generally conceded to be the introduction of the gonococcus at or soon after the time of birth. The prevention is an easy matter, and is of most importance to us.

During my service at the Emigrant Hospital, Ward's Island, New York, in the lying-in department, the vagina was douched with a sublimate solution (1:2000). As soon as the child was born the eyes were washed with a solution of common salt in water, about ten per cent. As a result, ophthalmia neonatorum was unknown in that institution during my service.

One of the great difficulties here is that many practitioners

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\*Read before the Chattanooga Medical Society.

will never see a case in the course of a large practice covering many years, and it is admitted that the danger is small in private practice, but as long as there is any danger at all and the method of prevention so simple and so sure, would it not be well to adopt these measures in all cases? Credé's method is to instill into the conjunctival sac a few drops of a two per cent. solution of nitrate of silver as soon as the child is born. This solution sometimes produces a considerable reaction, so that cold applications were used to lessen the inflammation, but this was rarely the case, and this inflammation never resulted disastrously. An application that would produce less reaction, and one that probably is as efficient, is the use of a solution of corrosive sublimate (1:3000) used in the same manner.

The diagnosis of these cases is easy, and is made from the secretion. But know more than this. It is of importance to know whether the cornea is involved or not, both for the treatment and for the prognosis. But right here we must not be too curious, for if we endeavor to inspect the cornea with a struggling child pressing the lids firmly together, we may exert enough pressure on the ball to break through the floor of an ulcer which has eaten its way to the membrane of Descemet. It is better to be satisfied with an unfinished diagnosis and to treat the case as though there were corneal complications present, than to take any unnecessary risks.

The prognosis depends on the condition of the cornea. The danger is only from the involvement of the structure. As long as we can keep this free from ulceration we have no fear of the result.

The treatment is one in which the authorities disagree in some particulars. We speak of the treatment under the following heads:

- 1st. Cleanliness. On this all are agreed. It is best accomplished by the use of a solution of boracic acid gr. x ad. ℥j., with which the discharge is to be washed from the eye as often as it accumulates, whether it be every ten minutes or every hour.

- 2d. The use of heat or cold. Here there is some difference of opinion, some teaching to use whichever feels the most com-

fortable to the patient, while others advocate the use of cold or heat exclusively.

When we consider the cause of the disease and remember that the cocci can be prevented from multiplying by a low temperature; when we know that we can produce this temperature in the conjunctival sac by actual observation; when we consider further the rapid changes, often destructive in character, produced by heat; and finally the fact that as a rule heat is not as well borne in these cases, we must conclude not only that cold applications are most rational, but that they are the best for the patient.

Cold is to be applied in the following manner: From twelve to fifteen pieces of white linen cloth two inches square are folded twice, slightly moistened and placed on a cake of ice alongside the bed. One of these is placed on the closed eyelids and allowed to remain there until it begins to get warm, when it is changed for a cold piece, and this is kept up, so that we have a continuous application of cold without any pressure, as we would have from the use of an ice bag, however small. This plan necessitates the employment of at least two nurses, for the applications are to be kept up night and day. To prevent a slight irritation of the skin which we sometimes have, we may rub a little vaseline on the outside of the lids and the surrounding skin. This employment of cold is not intended as an adjuvant to the treatment, but is to be relied on as the principal part of the treatment.

The 3d item in the treatment refers to the use of nitrate of silver. In the use of this drug oculists differ not only as to the stage of the disease when it is to be used, but also as to the strength of the solution. The practice at the New York Ophthalmic and Aural Institute is to use it in solution no stronger than 2 per cent. (gr. x ad.  $\bar{3}$ i). Some use much stronger solutions. The objection to this practice is that where there is an ulcer of the cornea, in some cases the silver has a bad effect. I remember in one case where the solution seemed to penetrate into the middle layers of the cornea, while the external layers seemed to be intact;

it seemed to decompose this layer, at any rate that eye was lost. Knapp employs the following method to protect the cornea. The upper and lower lids are everted at the same time, and the upper lid is allowed to descend until it covers the ball; we can then apply the solution so that none of it comes in contact with the corneal tissue.

The solution is never used until the secretion is well established, until the discharge becomes somewhat profuse. Many apply it in the early stage, and rely on it as the main line of treatment, while here it is regarded as an adjuvant.

The complications are the corneal troubles that too often accompany this disease. What we most dread is an ulceration of cornea. The cornea may be involved in three ways: 1st, by continuity of inflammation; 2d, by a choking of tissue at its margin, shutting off the nutrition: 3d, by direct infection. This is probably the most frequent way in which the corneal complication takes place. The roughened lids brushing over the delicate epithelium produce abrasions through which the acrid secretions gain access to the proper substance of the cornea. The two causes combined tend to make the ulcers deeper, until the membrane of Descemet is reached, which is not liable to give way unless some violence is used. Should this membrane be broken, the cocci would gain access to the delicate structure within the ball and set up an inflammation that could hardly fail to destroy the eye. Oftener, however, the eye is destroyed by the inflammation involving the whole of the cornea, which is then replaced with a cicatricial tissue; as this is not transparent the eye is destroyed for all practical purposes. The anterior part of the ball may shrink (phthisis bulbi). The opacity may not be so extensive as described. It varies from a faint nebula that can hardly be diagnosed, but may not interfere seriously with vision, to the total opacity just described. Atrop. sulph. (gr. jv ad. ʒi. is to be used for any acute corneal complication.

The treatment of the opacities does not always receive the attention that it should. Persistent treatment will clear up many of them in a wonderful degree. Where this cannot be done the formation of an artificial pupil behind a clear part of the cornea

is often indicated. Wherever there is any clear cornea and the patient has perception of light, he should have the benefit of an examination by an expert, for some that are now blind may be made to see.

As to the other eye in these cases, it should be protected. This can only be done by seeing that it is kept clean and that none of the dressings from the affected eye come in contact with it, directly or indirectly. We cannot seal up an eye to any advantage in an infant.

Those who are desirous of looking up this subject further are referred to an article by Weeks in the *New York Medical Record*, of July 24th, 1886.

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*Discussion.*—DR. COBLEIGH said that in a long experience he had never seen a case of ophthalmia neonatorum, but had seen many cases of catarrhal ophthalmia from the use of soap.

DR. KUYKENDALL said that the disease was more frequent in the cities. The gonococcus was found in 65 to 75 per cent. of the cases that had been diagnosed by good clinicians as the disease in question. Chlorine water is the best in the early stage. Every case can be saved if seen before the cornea is involved. One of the best authorities, D. B. Roosa, does not use the nitrate of silver at all. The use of the bichloride every half hour, if the cornea is involved, (1:4000) is good practice. If we can see only the lower part of the cornea, we can judge as to whether it is inflamed or not. If in doubt, treat as if there were an ulcer, but don't use too much force in making the examination, for the reason given in the paper. The use of silver by Knapp's method is not effective, because it does not reach the cul-de-sac where it is most needed. In cases where there seemed complete opacity he had seen surprising results from the use of calomel, but it is difficult to get these cases to keep up the treatment for years.

DR. TRIPPE believed in the use of the silver nitrate in strong solutions, and related a case where the two per cent. solution had no effect, and he got no good result until he increased the strength to gr. xxx ad. ʒi.

DR. TOWNES said that the silver may decompose when it comes

in contact with the tissues, by uniting with the albumen of the tissues and forming the albumate of silver. A better effect would be produced by cleansing the tissue first.

DR. RATHMELL asked Dr. Smith what he did for the pain in these cases and in similar cases for the adult.

DR. SMITH said that he gave anodynes when necessary to the adult, but in the infant we had no evidence that the disease was painful. Under no circumstances was cocaine to be used, as it had a tendency to interfere with the nutrition of the cornea. He wanted to emphasize the use of cold as the main reliance in the treatment, which he had probably not dwelt upon fully in the paper.

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SYNOPSIS OF REMARKS ON SYSTEMIC INFECTION  
FROM GONORRHŒA.—BY J. BEDFORD  
BROWN, M. D., ALEXANDRIA, VA.—  
ILLUSTRATED BY CASES.

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Dr. Brown, in his paper, cites five interesting cases of systemic poisoning from gonorrhœal infection. He believes that there are two channels for the absorption and conveyance or transmission of the gonorrhœal microbe into the general system. One is by continuity of surface over the mucous membrane of the genito-urinary tract from the urethra to the kidneys. The other channel is through the great lymphatic system, from the lymphatics of the urethra to the inguinal glands; thence through the lymphatics of the system into the general circulation. He believes also that this microbe so transmitted is lodged at different points in the organism. The gonorrhœal microbe, transmitted by continuity of surface over the genito-urinary tract, invariably induces specific suppurative inflammation. On the contrary, when transmitted through the lymphatics the inflammation is not of a suppurative character, but assumes peculiar types. The contact of the infectious microbe with the mucous surfaces produces suppura-

tive prostatitis, cystitis, ureteritis, pyelitis, then pyonephrosis. The absorption of the same through the lymphatic channels first sets up lymphangitis of the lymphatics of the urethra; then lymphadenitis of Cowper's glands; then of the inguinal glands; then inflammation of the connecting lymphatics. Then, by further absorption, it may induce septic phlebitis of the thigh, and finally synovitis. The question of systemic infection in the female from gonorrhœa through the uterus is omitted in this paper. He also believes that a genuine septic influence in certain cases of systemic poisoning, or in other words pyæmia, is developed, which his cases go to establish. He also believes that there is a marked relative difference in the susceptibility of different constitutions to the systemic poisoning of gonorrhœal infection, as in all other diseases, and that the infection of the system is only in certain cases.

The writer lays stress on gonorrhœal ureteritis as a part of the action of the gonorrhœal microbe in its travels over the mucous surface of the genito-urinary organs towards its final destination in this direction—the kidneys. It is accompanied with pain, at times sharp and paroxysmal, usually dull and creeping in character, along the trail of the ureter to the kidneys. These sharp paroxysms of pain extend upward to the kidneys, not downward as in nephritic colic. Then again there is soreness in the entire line of the ureter increased on pressure, so that the course of the canal can be marked out clearly. Ureteritis is always established before nephritis begins in gonorrhœal infection. The cases cited by Dr. Brown indicate that a state of pyæmia or septicæmia may be developed by the systemic infection from gonorrhœa in certain instances. Thus, he has seen septic infection from gonorrhœal prostatitis, cystitis, pyonephrosis, lymphangitis and endocarditis.

CASE I.—A young man, aged about twenty-three, contracted gonorrhœa. He was previously in perfect health. The first two weeks his case progressed favorably, when a decided chill and fever ushered in acute prostatitis and then cystitis, ending in ureteritis and pyelitis, and finally pyonephrosis of the left kidney, with constant pain and tenderness over the region of the or-

gan. Finally a large amount of pus appeared in the urine, which discharge of pus continued for three or four weeks. The urine, under the microscope, showed daily during all this suppurative stage as perfect and beautiful specimens of the malpighian bodies and uriniferous tubes as could be found in the most delicate anatomical preparations. Under a milk diet, bicarbonate of soda, quinine, the tincture of the chloride of iron, suppuration ceased and the man recovered with the loss of one kidney, and a closed ureter, but with perfect restoration of health.

CASE II.—A young married woman, aged about twenty-five, soon after marriage contracted gonorrhœa from her husband, but at the time was in a perfect state of health. The gonorrhœal infection extended from the ureter to the bladder, producing cystitis, then ureteritis, finally nephritis. The urine contained a large proportion of albumin. Both ureter and kidneys were involved in this case. These infectious inflammations were attended with great constitutional disturbances and depressions. There was continued fever, delirium, increasing stupor, then coma, and finally convulsions and death. There were all the symptoms present of septicæmia in the chills, fever and perspiration, the dry tongue, muttering delirium and coma. The history of this case, he thinks, suggests the thought that gonorrhœa may be more frequently the cause of nephritis, acute and chronic, than is usually supposed.

CASE. III.—The subject of this case, which he reports of an exceedingly interesting and remarkable character, was a young man of perfectly healthy character, aged twenty-seven. At about the tenth day of the attack of gonorrhœa symptoms of severe, acute prostatitis appeared, accompanied with violent pain in bladder and rectum and tenesmus, with frequent attempts at micturition. This was followed by complete retention of urine. It was impossible to introduce a catheter and aspiration was objected to. The urethra was douched by means of Davidson's syringe, with hot water containing cocaine, every half hour. This relieved the engorgement of the prostate and enabled the patient to void



urine spontaneously. The inflamed prostate continued to give trouble, when the acidity of the urine reached a high point. A half ounce of bicarbonate of potash daily sufficed to keep the urine neutral, which always relieved prostatic irritation and pain. Under treatment the prostatitis gradually subsided. Then a prolonged rigor and violent fever ushered in a genuine attack of gonorrhœal cystitis, accompanied with discharge of blood and mucus. The urine now became alkaline and deposited an abundance of triple phosphates. As a local measure peroxide of hydrogen was thrown into the bladder through a soft catheter and thirty grains of benzoic acid in capsules were taken daily. On subsidence of the cystitis, ureteritis on both sides, denoted by pain and tenderness over the course of the ureters, came on; then desquamative nephritis, in which the urine contained albumin and casts and blood. Under the free use of benzoic acid, salol, iodide of potassa, the ureteritis and nephritis passed away, and the patient congratulated himself on his recovery after a confinement to bed for two months. In this he was disappointed. There was a slight return of ureteritis. Then there was lymphangitis in the lymphatics along the corpus spongiosum. Then the glands of Cowper became involved, and finally the inguinal glands. These glands became intensely swollen and inflamed, and the lymphatic vessels connected therewith became involved in the process, indicated by numerous red lines radiating over the groin and lower abdomen. There were also patches of erysipelatous inflammation. These local affections were accompanied with serious constitutional disturbance, as chills and fever. The lymphadenitis and lymphangitis were treated locally by means of an ointment containing iodine, iodoform and ichthyol. Internally ten grains of quinine and one grain of sulphide of calcium three times a day. The local affection subsided entirely under this treatment, but now the gonorrhœal infection localized itself on another structure.

In the femoral and saphenous veins a violent form of phlebitis appeared, preceded by chill and high fever. The veins became large, corded and painful. This complication was treated by the same ointment, quinine and tincture of iron, and ulti-

mately passed away. But in a few days a most violent attack of gonorrhœal synovitis set in, heralded by chill and fever, involving the ankles, knees and hip joints. Under the phenacetine, salol and iodide of potash, the rheumatism subsided in about three weeks. This was followed by double orchitis, which was successfully treated by twenty grains of bromide of potassa, and five of the iodide every three hours. This was the last complication, and closed the history of the most extraordinary case of gonorrhœal poisoning on record. His patient was confined to the house about four months, and was in almost an exhausted condition.

CASE IV.—Male, aged 45, contracted gonorrhœa. Prostatitis ensued, with retention of urine. The urine was alkaline, but contained no albumin. Small abscesses formed in the prostate, symptoms of true septicæmia developed, consisting of chills and fever, and perspirations. The tongue became dry and brown, and there was complete loss of appetite, with nausea. Muttering delirium set in, then coma and death.

CASE V.—Male, aged 18, contracted gonorrhœa. In the third week severe gonorrhœal synovitis appeared in the joints of the arms and legs. Then septic endocarditis followed. With this there was high grade of fever, with adynamic or typhoid tendencies. Then, when convalescing from this complication, there suddenly appeared lancinating and intolerable pain in the center of the left eye, without conjunctivitis; then choroiditis and sclerotitis and loss of vision; then abscess and ulceration, and rupture of the cornea and destruction of vision. Iodide of potassium, the salicylates and alkalies exerted no effect whatever on the course of the disease.

The character of the disease was septic throughout. The writer believes that the microbe, when absorbed into the system through the lymphatics, is capable of assuming the character of a septic agent.

The writer believes that the gonorrhœal microbe, when absorbed into the system, either through the genito-urinary tract or lymphatics, wherever it finds lodgement, there it suspends or disturbs the process of sensation in the part, and sets up metabolic changes that induce inflammation, suppuration and destruction. Fortunately, the cases of its extension in absorption beyond the prostate glands or lymphatic glands of the groin are rare and exceptional.

## BLENNORRHŒA.

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ABSTRACT OF PAPER READ BEFORE THE MISSISSIPPI VALLEY MEDICAL ASSOCIATION BY DR. JAMES T. JELKS, OF HOT SPRINGS, ARK. Formerly a member of State Medical Society of Georgia; a member of Arkansas State Medical Society and Medical Association; late Professor of Surgical Diseases of the Genito-Urinary Organs and Venereal Diseases, in College of Physicians and Surgeons, Chicago, Illinois.

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Ricord's conclusion that gonorrhœa was a non-virulent disease has been relegated to the rear by finding the gonococcus of Neisser. All efforts to produce a blennorrhœa with ordinary pus have failed. Every effort to produce the disease with the discharge of the first stage of the disease where the pus corpuscles are few succeeds.

The identity of blennorrhœa neonatorum and ordinary gonorrhœal disease has been established.

Neisser demonstrated the gonococcus in 1879. His conclusions were confirmed in 1880 by Bokai and Finkelstein. These men cultivated the gonococcus, and with the pure cultures produced typical urethritis.

Bockhardt, in 1883, reported the results of his examinations. In 258 cases he invariably found the gonococcus. He likewise cultivated it, and with the culture produced blennorrhœa. Keyser in sixty cases found the same germ.

In 1884 Zweifel reported that only that pus which contained the gonococcus of Neisser could produce blennorrhœa neonatorum.

Bumm confirmed these statements of Zweifel.

Sternberg, in 1884, disputed these statements of Bumm, Neisser, Bokai, Finkelstein, Bockhardt, Zweifel, Willands and many others. With Sternberg we find Sanger, Frankel, Gervanin, M. von Zeisel and Lustgarten and Mannaberg.

In 1886 Bumm again wrote concerning the coccus of Neisser.

In numerous cultivation experiments he demonstrated the presence of this coccus, and with pure cultures of the 2d and 29th generation produced, in two women, typical urethritis and

in the discharge was found the gonococcus. This, then, is a demonstration that urethritis is a specific disease.

This specific disease of the urethra is in a large majority of cases limited to the anterior portion of the canal. When the posterior is involved it should be looked upon as a complication and treated as such by cessation of all treatment of the anterior urethra and rest in bed.

You are all familiar with Fournier's celebrated statement as to the sources of infection. Out of 387 cases the disease was acquired from regular prostitutes twelve times; and in 375 cases from clandestine prostitution!

Bumm's experiments with pure cultures in the eyes of rabbits has enabled us to follow the gonococcus in its travels. First they multiply upon the epithelium. In a few days they penetrate this layer of the mucous membrane—and henceforth propagate within and upon the papillary layer. This process of sub-epithelial multiplication of the gonococcus for the first two or three weeks of a blennorrhœa is one of great importance to us; and not until the decline of the disease is this process changed to one of surface multiplication. This is a very important fact for us, and explains why all of our efforts to jugulate the disease have failed. It is true that surgeons, years ago, used strong solutions of silver nitrate, twenty to forty grs. to the oz. to abort the disease, and sometimes succeeded; but when they did it was because this strong remedy destroyed the epithelium, and hence reached the coccus beneath it; but the remedy was worse than the disease.

#### TREATMENT.

I will not go over all the old remedies and modes of treating blennorrhœa, but call your attention to Prof. Stilling's experiments with Merk's Pyoktanin. He used it successfully in blennorrhœa neonatorum. Last winter I heard Dr. Holtz read a paper before the Chicago Medical Society giving his experience with pyoktanin in gonorrhœal ophthalmia.

By reason of the fact that pyoktanin penetrates the epithelial covering and into the papillary layer, it occurred to me that this

was the remedy for blennorrhœa; and I once instructed the attending staff in the Genito-Urinary Department of the West Side Free Dispensary of Chicago to use it.

Upon my return home I commenced its use in my private practice. Some of the cases have gotten well with marvellous rapidity, a few in twenty-four to forty-eight hours. Again others have obtained no benefit from the remedy. I am not able to tell why this should be.

On June 13th, 1891, Dr. George Wiley Broome, of St. Louis, Mo., read a paper before the St. Louis Medical Society, wherein he advocated the use of pyoktanin in blennorrhœa. His method was to insufflate the dry powder. My plan has been to use a saturated solution as an injection, retaining the fluid for five or ten minutes and by pressure forcing it down to the isthmus.

I am sure that the treatment of the future will lie in getting some remedy which has the power of penetrating the tissues and hence reach the disease germs.

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ASSOCIATION OF AMERICAN MEDICAL COLLEGES.—The Association of American Medical Colleges held its second annual session recently in Washington, when a permanent constitution and by-laws were formally adopted. The object of the Association is to raise the standard of education, both general and technical, required for admission to the medical profession. Colleges becoming members of the Association undertake to demand of candidates for the degree of M. D. that they shall attend at least three full courses of medical lectures of not less than six months each, no two of these courses being in the same year. They must further require candidates for admission to the courses to pass an entrance examination on a scheme prepared by Dr. W. Osler and Dr. Millard, which includes writing "legibly and correctly" an English composition of not less than 200 words, the translation of an easy piece of Latin prose, higher arithmetic or the elements of algebra, and elementary physics. Only graduates or matriculated students of recognized colleges of literature, science, or arts are to be exempted from this examination, which is to come into force in 1892. On the whole, the requirements can hardly be called oppressive, but they appear to have been sufficient to damp the zeal of more than one of the colleges which had shown a disposition to join the Association.—*Exchange*.

## Society Reports.

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### TRI-STATE MEDICAL SOCIETY OF ALABAMA, GEORGIA AND TENNESSEE.

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THIRD ANNUAL MEETING, HELD IN CHATTANOOGA, OCTOBER  
27, 28, AND 28.

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#### FIRST DAY.

Society called to order by Vice President B. T. CAMP.

Opened with prayer by Rev. D. Vance Price.

The Committee on Necrology offered a set of resolutions on the deaths of Drs. T. F. Cary of Florida, W. B. Wells and W. P. Craig, both of Chattanooga, which were adopted.

After the reports of committees and the transaction of some miscellaneous business, Dr. S. S. Kerr read a paper reporting a case of "Neuro-Mimetic Hip" trouble, and presented the patient.

This was a case in which the diagnosis of gonorrhœal rheumatism had been made, but he was unable to see the case in that light. The nervous system and the family history indicated a nervous element, and there was an hysterical element in the case. A partial cure was effected by suggestion, but the patient still walked on his toe, for which he could see no reason, as there was no shortening nor tenderness about the hip, or other signs indicating organic disease.

DR. TRIPPE said that he had treated the case before Dr. Kerr. The patient had gonorrhœa four weeks before he saw the case. There was increased temperature,  $102^{\circ}$  to  $104^{\circ}$ . There had been two marked chills and a typical picture of gonorrhœal rheumatism, although an hysterical element was recognized in the case.

DR. REEVES thought the case one of involvement of the cord, in which there was an attack of gonorrhœa, and that this set up a new train of reflexes. He called attention to the fact that every discharge from the meatus was not a gonorrhœa, and as a test he stated that the discharge from a specific case was acid, from a non-specific alkaline.

DR. J. B. COWAN thought that the history as given by Dr. Trippe indicates some specific trouble, and if most of the members had seen the case it would have been diagnosed as gonorrhœal rheumatism. Where we have such a specific trouble and a history of masturbation as here, we would expect some hysterical symptoms. A man may have an hysterical joint just as a woman may have the globus hystericus.

DR. DRAFE, from the history and an examination, thought the case one of gonorrhœal rheumatism.

Whenever there is a pain there must have been a cause, past or present.

DR. KERR had nothing to say as to the condition before he saw the case. He agreed that there were neurotic symptoms. It was a difficult task to make a diagnosis. He had brought the patient so as to find out how to make him stop walking on his toe, for which he could see no reason.

#### AFTERNOON SESSION.

President ROBERT BATTEY presided.

Dr. E. T. CAMP of Gadsden, Ala., read a paper on

#### THE SUMMER DIARRHŒA OF CHILDREN,

in which he gave as the causes, 1st, improper food; 2d, high temperature; 3d, micro-organisms. In some cases there was a neurotic element. He reported one case where the diarrhœa was cured by circumcision, there being no change in the other treatment.

DR. BATTY asked if any of the members had any experience that would confirm the views of the writer that the prepuce might keep up the diarrhœa.

DR. GAHAGAN had a case of persistent diarrhœa in which there

was an elongated prepuce. He would circumcise the case and report next year.

DR. COWAN had not noticed that male children were more subject to diarrhœa than females. There was often fault in the diet, both as to quality, and especially quantity.

DR. BERLIN called attention to the fact that the Jewish children have diarrhœa as frequently as the Gentiles, and could see no connection between a stomach loaded with bacteria and an abnormal prepuce.

DR. J. L. ATLEE confirmed the experience of Dr. Camp. He had seen cases in which, after circumcision, the diarrhœa began to improve with no change in the other treatment.

In closing Dr. Camp said that he had reported but one case in his paper, but that he had seen a number of others in which there was a like result.

DR. GEORGE WILEY BROOME, of St. Louis, read a paper on

REPORT OF A SUCCESSFUL CASE OF KOLPO-HYSTERECTOMY, INCLUDING A BRIEF REVIEW OF THE PRESENT STATUS OF THE OPERATION.

in which he advocated the operation in all cases of epithelioma or carcinoma of the cervix, or of the body of the uterus, regardless of the extent of the disease. Amputation of the uterus should never be performed.

DR. DAVIS' experience had been that these cases when sent to him were too far advanced to justify an operation. He had not been convinced, where but a limited part of the cervix was involved, that an amputation was not as good as the radical operation. Many cases were morphine eaters, and the condition of the intestinal tract was one of importance.

DR. BERLIN thought the total extirpation was better than high amputation. When the disease had passed beyond the uterus it was too late to amputate in any way.

DR. BATTEY had grave doubts as to the advisability of the operation. In the early stage the diagnosis was difficult. In some of the cases sent him as cancerous, cures were effected by



the application of iodine, etc. Of the cases cured he had grave doubts as to the diagnosis. On the other hand there were many deaths after the operation, if not immediately, within a short time. As in the case of Sen. Hill, many will not consent to an operation until a malignant growth has advanced beyond the stage when it can be removed.

DR. KEY preferred the clamp to the ligature. Early diagnosis is of importance, and this can only be made by an expert pathologist, and as soon as made the uterus should be removed.

#### NIGHT SESSION.

Addresses of welcome were made by Dr. J. R. Rathinell, President of the Chattanooga Medical Society and Col. Garnett, Mayor of the city.

DR. ROBERT BATTEY responded on behalf of the society.

DR. GEORGE E. WEST reported

#### TEN CASES OF LAPAROTOMY,

with one death. Three were for the removal of diseased ovaries and tubes, one for the cure of oöphoro-epilepsy, one for the removal of ovarian cyst, three for the relief of symptoms caused by uterine fibromata, two exploratory incisions. Of the nine recoveries six were perfect cures, three partial cures from incomplete operations.

DR. DAVIS said that it was the improved technique that gave success in these operations, which required not only book knowledge, but also special training.

DR. BROOME advocated early operation. He insisted on sterilizing the instruments, and indorsed Arnold's sterilizer. Morphine should never be given after a laparotomy.

DR. REEVES felt grateful to the author for his remarks on conservatism. He quoted Dr. Mitchell, who said that in his experience he had sent thirteen cases to the surgeon. Five of these were not improved. Dr. Gardner had said that the majority of cases operated on were not any better five years after the operation.

## SECOND DAY.

Opened with prayer by the Rev. J. W. Bachman.

After some miscellaneous business Dr. Robert Battey addressed the Association on

## OVARIOTOMY; ITS USE AND ABUSE.

He said that the fundamental idea in the operation he had devised was to produce rest. The difficulty of curing many chronic diseases lies in the fact that rest is an impossibility, as with the heart rest means death. Rest is an impossibility to an ovary.

The objects of the operation are—

1st. The prolongation of life. Years ago Sir Spencer Wells said that he had added 3000 years to the sum of human life ; now it is probably double that.

2d. The restoration of a disordered mind. There is a prejudice against the operation, owing to the fact that cases have not been properly selected, and alienists want the ovariologist to cure their cases after they have exhausted every other means of cure, when it is often too late.

DR. GOODELL asserted that an insane woman had no business with children.

DR. BATTEY would hardly go so far.

3d. The cure of epilepsy. As in the case of insanity, there should be some connection between the epilepsy and the ovaries. It does not follow that because a woman has epilepsy that her ovaries should be removed. Here Dr. Goodell had good results.

4th. The relief of intolerable pain. Especially when the pain has a tendency to produce that detestable habit, opium eating, a habit little short of insanity. Where the habit has been formed the operation will cure the case if the woman can break the habit.

One of the abuses of the operation is to perform a single operation for the sake of the notoriety it would bring. This ought to be a specialty as much as the eye. Success depends on the

skill of the operator, which can only come from experience. It depends also on native ability, and every man should study his natural talents in the light of statistics, and choose the field where he is most successful.

The operation of ovariectomy to stop child-bearing is a detestable practice. The operation should never be done without ample consultation, first, to protect the physician; second, in the interest of the profession at large; third, in the interest of the patient.

DR. DAVIS thought that as much could be done by simply incising the muscle as by a normal ovariectomy. The operation has no place in the treatment of nervous diseases.

DR. BROOME suggested that as it was well known that ovariectomy produced atrophy of fibroid tumors by cutting off the blood supply, therefore ligation of the uterine artery might produce as good results.

DR. WILSON advocated the operation in cases of mania; did not believe that insane women should have children.

To confirm Dr. Battey's views, Dr. Cowan reported a case of epilepsy cured by the operation.

DR. BATTEY, in closing, gave the indications for the operation, as follows:

1st. The case must be desperate. 2d. It must be incurable by ordinary means. 3d. There must be a reasonable hope of cure.

In the last two years he had advocated the removal of senile, diseased ovaries for the cure of insanity, citing cases.

DR. W. E. B. DAVIS, of Birmingham, Ala., read a paper entitled

TREATMENT OF INFLAMMATION ABOUT THE HEAD OF THE COLON, in which he said that cases must be selected for the operation; important symptoms must not be masked by the administration of opium. More reliance should be placed on regional tenderness than on the temperature. An inflammation about the head of the colon is always an appendicitis, the involvement of surrounding tissues being secondary. Early operation is necessary.

DR. CUNNINGHAM was of the opinion that the whole question

should be rewritten. The peritoneum is always involved to a limited extent.

DR. SHIMWELL said that the temperature may not be increased, and related a case confirming the statement. There is no rule when to operate ; each case must be judged on its own merits.

DR. KARL VON RUCK, of Asheville, N. C., read a paper on THE CURE OF TUBERCULOSIS ON THE PRINCIPLE OF NUTRITION, in which he said that the diagnosis with the microscope could not be made in the early stage. No one measure should be relied upon in the treatment. He was surprised that greater harm had not been done by the large doses of tuberculin that had been used. In the early stage the treatment was often inefficient, when the cases could be cured. Climate was of importance, and all measures that could benefit the patient should be employed.

DR. REEVES advised the use of the microscope in all cases to confirm the diagnosis ; if it be not tuberculosis it is syphilis. Primarily the disease is due to lymph stasis.

DR. VON RUCK called attention to the fact that in the early stage there is no sputum and no bacteria, so that the diagnosis cannot be made with the microscope.

DR. J. C. SHAPARD, of Winchester, Tenn., read a paper on

#### MILK SICKNESS,

stating that the disease existed only in a limited area; that it was contracted from the cow. The poison seemed to be neither animal nor vegetable, but mineral. The disease called trembles in the cow resembled lead poisoning in man.

DR. COWAN said that the subject was of so much importance that the Government had offered a reward for the discovery of the cause. He had seen one case, and thought at first that it was one of lead or cobalt poisoning.

DR. REEVES said that the bacteria had been found; that they were spirilli, for which quinine was the best remedy.

DR. J. B. MURFREE, of Murfreesboro, Tenn., read a paper on

## THE NECESSITY FOR ASEPSIS IN PRIVATE OBSTETRICAL PRACTICE.

He advanced the idea that it was more necessary to protect the wounded surface here than in an open wound. The decreased mortality in hospital practice he thought due to the use of antiseptics. In private practice cleanliness was necessary, and sometimes antiseptics ; especially should the hands be clean, and the examinations be as few as possible.

DR. BAXTER indorsed the paper in the main, but thought that in private practice the danger of infection was ten times as great as in hospital practice. The nurses should be watched, as they know nothing of surgical cleanliness.

DR. SHIMWELL thought the injury to the mother was a factor in these cases that was overlooked. Wherever there had been a *post mortem* great injury to the tissues had been found.

DR. GOWAN thought the great secret was cleanliness, but that antiseptics have their place.

In a large number of cases observed Dr. Wilson had not found the results any better with antiseptics than with simple cleanliness with sterilized water. The results were as good where the patients were aggregated as where they were segregated. Vaginal irrigation was not necessary, for the cases did as well by simply washing the vulva.

DR. CUNNINGHAM thought with Dr. Shimwell that the result was often due to traumatism. He always uses the Credé method of expelling the placenta.

## NIGHT SESSION.

At 8 P. M. an elegant reception was tendered the members at the residence of Mr. and Mrs. M. R. Wilson, 229 East Terrace.

## THIRD DAY.

## MORNING SESSION.

Opened with prayer by Rev. Robt. J. Willingham.

DR. N. G. BOGATR, of Chattanooga, read a paper on

## LACERATED CERVIX.

He advocated the operation only when there were troublesome symptoms produced by the laceration, and other measures fail.

He described the operation mainly as laid down by Skeene. The cause of failure was imperfect preparation of patient, imperfect operation or imperfect after treatment.

DR. CAMP said that it was necessary to remove all the cicatricial tissue; silver sutures the best; douches not necessary. He does not indorse the use of ergot after delivery.

DR. DAVIS said the paper presented the present status of the operation. The condition requiring it could be prevented by proper attention after confinement. Ergot is of use after confinement, not only to cause contraction of the uterus, but it also closes the mouths of the small vessels and lessens the danger of septic poisoning. He examines all of his patients six weeks after confinement if possible. In subinvolution the faradic current is of value, despite the assertions of many that electricity is of no use in gynæcology.

DR. REEVES had gotten good results in these cases by supporting the womb with a Fowler pessary, and had cured some by this means. He gave minute doses of ergot after confinement.

DR. BOGART, in closing the discussion, said that he gave support to the uterus in these cases, but that he preferred to do this with medicated lamb's wool tampons, instead of using a hard rubber pessary.

DR. G. W. DRAKE, of Chattanooga, presented a paper on

#### THE PHYSIOLOGY AND CHEMISTRY OF THERAPEUTICS.

In this he maintained that the infectious diseases are caused by ptomaines or toxines evolved by bacteria in the body. He proclaimed that "chemical antagonism" was the safest, the most scientific and most rational means of cure, rather than that of "physiological antagonism." He argued that all bacterial toxines had an antidote for which we should look. The tendency was to return to specific medication along more scientific lines. The age demands rational medicine.

DR. PURDON called attention to the fact that the antiseptics were used thirty years ago empirically, for he had used the permanganate of potash in cholera; he had also used the peroxide of hydrogen.

DR. B. T. SHIMWELL, of Philadelphia, read a paper on

ARTIFICIAL ANUS VS. ANASTOMOSIS.

DR. JOHN E. PURDON, of Cullman, Ala., read a paper on

THE CONSERVATISM OF ENERGY IN MODERN PHYSICS,

in which he claimed that in the face of established facts of mental and physical action at a distance, nothing was left to the physiologist but to acknowledge the existence of an extra muscular mode of the externalization of energy in relation with conscious or sub-conscious will and design. He held the opinion that the ether of space had its physiological as well as its physical side, and that, as the reservoir of the working power of the universe, it bore a relation to the Universal Life analogous to that which the blood and nervous system held to the individualized spirit. He based his theory of an ethereal nervous medium upon the results of his own sphygmographic researches which showed the similarity of the pulse traces of individuals *en rapport* during extraordinary manifestations of energy, such as "knockings" and "telepathic influence." Dr. Purdon deposited publicly with the secretary the photographs of a selected set of pulse tracings, taken by himself, in illustration of the above view, and claiming the absolute originality of the method for himself.

DR. COWAN said that the grandest result of energy was thought, by the arrangement of matter, by the correlation of force we have this power. This we derive from solar force.

DR. CUNNINGHAM thought that we know nothing about the matter.

DR. DRAKE took issue with Dr. Cowan, that the original force was solar, for energy existed before the sun was made, and came from the Deity. To this Dr. Cowan assented.

DR. J. P. STEWART, of Attalla, Ala., read a paper on

EVOLUTION FROM A SCIENTIFIC STANDPOINT,

in which he advocated the doctrine from scientific considerations.

DR. DRAKE said that the reproductive energy in the human ovum was the unseen hand of God moulding its protoplasm into perfect form.

DR. PURDON said that man belongs to a different class from the lower animals. Evolution is true as a formula, as a partial formula.

## AFTERNOON SESSION.

DR. HENRY WM. BLANC, of Sewanee, Tenn., gave his experience in

A REVIEW OF FIVE YEARS OF DERMATOLOGICAL PRACTICE IN  
NEW ORLEANS.

He reported 2,013 cases seen in public and private practice. Twenty per cent. were eczema, elsewhere the per cent. is thirty or thirty-five. Epithelioma in the form of rodent ulcer figured conspicuously in the report. A large number of leprosy cases were reported. Many of these cases were of foreign birth, or children of foreigners. The author believes in the contagiousness of leprosy, but thinks that in many of his cases the disease was contracted from some animal source, as in eating raw meat, or in preparing meat for the table.

DR. R. M. CUNNINGHAM handled the subject of

## CROUPOUS PNEUMONIA.

A paper was read by Dr. Y. L. Abernathy, of Hill City, Tenn., on

## DOCTORS.

DR. W. P. McDONALD, of Hill City, read a paper entitled

## LEGISLATION,

which was not discussed, as it dealt with matters of a political nature.

## NIGHT SESSION.

DR. W. C. TOWNS read a paper on

## ANGINA PECTORIS,

in which he gave as the conditions in the disease 1st, pseudo-angina pectoris; 2d, that form in which there is sclerosis of the coronary arteries; 3d, where there is valvular disease. The treatment depends on the cause. In the first form we have a



neurosis, and we correct anything we find at fault with any of the organs; secondly, we give tonics, potassa iodide, arsenic, nitrites, thirdly, we prescribe during the attacks such drugs as amyl nitrite, chloroform and opium.

DR. DRAKE thought angina pectoris a symptom, rather than a disease, sometimes the result of organic lesions, but often merely a cardiac neuralgia. He uses nitro-glycerine with atropia for the pain.

DR. PURDON gives as routine treatment the salicylate of soda where it is caused by cold (lowering of temperature). This is combined with strophanthus to prevent relapse.

DR. CAMP believes it to be due to a rheumatic diathesis, and uses chloroform by inhalation.

DR. WERT would be afraid to give chloroform owing to the pathology.

DR. PURDON said that by no means must electricity be used.

DR. BAXTER did not think chloroform specially dangerous, and cited cases.

DR. CUNNINGHAM believes in giving atropia and nitrite of amyl. He did not consider an intermittent pulse to contraindicate chloroform.

DR. TOWNS closed by saying that he did not lay much stress on the above treatment.

#### NIGHT SESSION.

DR. E. H. KUYKENDALL, of Chattanooga, read a paper on

##### BROMIDE OF ETHYL AS AN ANÆSTHETIC,

advocating its value and safety when given for short operations (one minute) and in dose of not over a dram. It is given free from air, anæsthesia is complete from one half to one minute. The effects last about two minutes, when the patient wakes as from a natural sleep. Nausea is seldom produced.

DR. DAVIS said that one accustomed to give ether was not safe to give chloroform, and it might be so with this; the deaths may have been due to faulty administration. Nitrous oxide was a rapid anæsthetic, and was considered the safest.

DR. SMITH suggested that if the doctor would give the number of cases observed by him that it would be of interest.

DR. BERLIN said that an objection was the odor. He related two cases of death from the drug.

DR. GAHAGAN asked Dr. Kuykendall for the mortality, how anæsthesia was produced and the antidote.

DR. KUYKENDALL replied that there had never been a fatal case unless the administration was prolonged. Dr. Chisholm had used it in three hundred cases without a bad result. So far as he knew there had been but two deaths. He did not know how it kills, or how it produces anæsthesia. The antidote is the same as in threatened death from chloroform.

DR. WILLIS WESTMORELAND, of Atlanta, discussed

#### BRAIN SURGERY,

saying that the surgeon had gone into the brain where the physiologist had said that he could not go. An exploratory incision into the brain substance was just as justifiable as in laparotomy. In abscess and tumors there has never been a cure without operation; where the incision has been thorough the results have been good. The safeguard is antisepsis, without which there is uncertainty. In operating, the ventricles must be avoided.

DR. DRAKE argued that surgeons had never gone farther than the physiologist had mapped out for them. They dare not invade the fourth ventricle in the vicinity of the respiratory center.

DR. WESTMORELAND reminded Dr. Drake that it was not due to the physiologists, but to the fact that some years ago a man had recovered after a crow-bar had gone through his brain.

DR. BERLIN related a case of insanity coming on after an injury to the skull cured by the same means.

DR. CRUMLEY believed that all functions were localized. Some areas can be invaded, others cannot.

DR. CUNNINGHAM said that most of these cases would die without operating, and that the surgeon was justified in doing anything that offered the least hope.

DR. STEWART reported a case of brain surgery where the whole frontal bone was taken away.

DR. WESTMORELAND said that to Dr. Briggs was due the credit of being one of the first to do this work. The success depends largely on drainage, and it may be necessary to make a counter-opening.

A paper by W. L. Bullard, of Columbus, Ga., was read asking  
SHOULD NOT OCULISTS BE MORE CAREFUL IN PRESCRIBING  
COLORED GLASSES?

in which he showed that the smoked glasses were generally better than the colored glasses, and that there was a more serious objection to the curved glasses, for the reason that they possessed some refractive power when we wanted a plain glass.

The following are the officers for the ensuing year:

President, W. E. B. Davis, Birmingham, Ala. Vice-Presidents, D. H. Howell, Atlanta, Ga. ; J. C. Shapard, Winchester, Tenn.; J. P. Stewart, Attalla, Ala. Secretary, Frank Trester Smith, Chattanooga, Tenn. Treasurer, B. S. Wert, Chattanooga, Tenn. Recorder, W. L. Gahagan, Chattanooga, Tenn. Councilors, J. B. Murfree, A. B. Frix, John E. Purdon, G. W. Drake, J. W. Clements, E. T. Camp.

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We regret to note that our esteemed picturesque contemporary, the *Dixie Doctor*, which has boasted of being so lively, and robust, and healthy, and vigorous, has been suffering with some catamenial irregularities of late. She has missed some of her monthly periods, and her menstrual functions seem to be getting deranged. Her last appearance, the October *issue*, came "past the time," and was much diminished in volume. Can it be that one so young, at one time so promising, at all times so hopeful, should be slowly undergoing her "change of life" so soon? We hope that the gentleman who directs the functions of the *Dixie Doctor* will apply the suitable remedies to establish a normal equilibrium.

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Another epidemic of the influenza has broken out among the Russia peasants. It is now prevailing in Russia and Germany.

## Correspondence.

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### A WOMAN'S LEG LITERALLY ROTTING OFF WITHOUT HEMORRHAGE; AND BONE SEPA- RATING WITHOUT ASSISTANCE OF PHYSICIAN.

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HUNTSVILLE, ALA.

*Editors Atlanta Medical and Surgical Journal :*

Two years since an interesting case fell to me to treat, and I give you details. I was called in to see Mrs. James Bird, near Huntsville, Ala., and found her six months *enciente*; and two small spots on the inside of either limb. Patient complained of intense burning extending down from both spots and involving both feet and ankles. A peculiar diffusible red now set in from both spots, and patient had erysipelas in both limbs. I gave sulph. of quinia and muriated tinct. of iron, and succeeded in curing the trouble in five days. The patient was so feeble and anemic I informed the husband of my apprehensions about the mother carrying the fetus to term. I placed her upon a tonic, and was call hastily in three weeks to the mother again. I found her in hard labor, and did not succeed in delivering in thirty-six hours. The two spots now returned in same place above the ankles on both limbs, and the erysipelas with redoubled vigor attacked both limbs, extending to within two inches of the knee. On the sixth day I discovered that gangrene had set in; the right side of the face, tongue and head turned black, and the whole system seemed permeated with the poison. I informed the husband of her great danger, and the patient said she preferred to die in peace rather than undergo operation. I did not think she could stand chloroform, and was confident the nervous shock would prove fatal. The line of demarkation between healthy flesh was well marked, and all the flesh dropped off from two

inches below the knee to ankle, leaving the two bones bare and the ankles as black and dried up as an Egyptian mummy. She would not allow me to remove the limb and in attempting to turn herself in bed the bone separated two inches below the knee. There never was a particle of hemorrhage, and the flesh gradually covered the bone, and the stump is a good one. There is no tenderness or feeling in the stump, and Mrs. Bird has grown fleshy and in better health than she ever enjoyed in her life.

Truly Nature is a wonderful restorer, and this case is so remarkable I concluded it ought to be reported.

The child lived three days, and the mother, always feeble before this trouble, now looks as if she would live to old age.

J. H. RIDLEY, M. D.

LIVE OAK, FLA., November 25th, 1891.

*Editors Atlanta Medical and Surgical Journal, Atlanta, Ga.:*

DEAR SIR—We have a little girl in this county four years old who is a fully developed woman in every respect, and was that way at two years and nine months. Can this be excelled in any land or country?

Very respectfully,  
S. T. OVERSTREET, M. D.

Since our last appearance, three of Atlanta's prominent physicians have entered the holy bonds and delightful estate of wedlock—Dr. J. W. Hood, Dr. C. C. Greene and Dr. Clarence Johnson. The gentlemen and their better halves will please accept the JOURNAL's distinguished considerations and best wishes.

WE regret to announce that Dr. Kennedy, of the JOURNAL, is undergoing an attack of typhoid fever. At this writing the disease seems to be under control, and we presume Dr. Kennedy will soon be convalescing.

At any given time in the United States it is estimated that there are two million persons afflicted with syphilis.

## Editorial.

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*With this special issue of THE JOURNAL, the proprietors have concluded to reduce the subscription price to two dollars per annum, in advance. We have been induced to make this reduction for several considerations, one of which is, the matter of convenience to our subscribers who choose to send their money by mail. THE JOURNAL is in better condition to-day than ever before, and it is the wish, and will be the effort, of the editors and proprietors to give our readers the best journal for the price that is published in the South.*

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## MEDICAL EDUCATION.

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(The following article is an abstract of an able and timely paper read at the late meeting of the Virginia Medical Society by our friend, Dr. Chas. M. Blackford, of Lynchburg. We only regret that we cannot print the paper in full.—ED.)

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The facilities for instruction, which the medical student of to-day enjoys, are superior in many respects to those of his predecessor of the last generation. The reduction in price of the higher literary learning enables him to receive a better preliminary training than was formerly available, and the liberal endowments of medical schools and hospitals give laboratory and clinical opportunities that before had to be sought in the great universities of the Old World.

But as the strength of a chain is but the strength of its weakest

link, so the merits or demerits of our American system lie not so much in the opportunities which the student may embrace, as in the proficiency required of him before he is declared by his college to be fitted to practice. I have before me as I write the annual announcements of twelve American medical schools, and of these one requires twenty-seven months' study for its degree, two require twenty-one months, one requires twenty, two require eighteen, one requires fifteen, four require twelve and one requires ten. These all require at least two, and many three, terms, but the collegiate year in but one of these colleges exceeds seven months, and in one is but five. When the varied scientific information which is demanded of the physician to-day is considered, it seems hardly possible that a satisfactory knowledge of the science of medicine, to say nothing of the acquirement of the art of treatment, can be obtained in so short a time. In three years, a young man is expected to become a master of Anatomy, Chemistry, Physics, Physiology, Materia Medica, Hygiene, Surgery in all its branches, Medicine and Medical Jurisprudence, to say nothing of Pathology, Bacteriology and Electricity. According to published statements, the same course requires five years in England and eight in Germany, and making all due allowance for the genius of American students, the discrepancy is striking.

As a result of the ease with which diplomas may be obtained under our present system, many States, including our own, have found it necessary to establish boards of examiners whose duty it is to see that applicants for licenses are properly educated. The finding of this board in Virginia is far from reassuring to those States in which no such law exists, for, from their report for 1888, we find that 22.5 per cent. of the applicants before it have been refused license. New York has also attacked this evil, and has struck at its source by prescribing a three years'

graded course as necessary for the degree of Doctor of Medicine from any of her schools, and requiring intending matriculates to undergo a preliminary examination in arithmetic, geography, grammar, orthography, American history, English composition and the elements of natural philosophy. This examination is not conducted by the authorities of the medical schools, but by the Regents of the University of New York. In thus putting the entrance examination in the hands of those who are not interested financially in the admission or rejection of candidates, a great step in advance has been made. In addition to this provision, intended to raise the educational grade of those entering on the study of medicine, a State Board of Medical Examiners has also been established whose duty is similar to that of the Virginia Board. In North Carolina a like safeguard exists, as also in a few other States. In this way a protest has been made by some of our legislatures against the reckless way in which too many of our schools grant diplomas, but so long as there is no limit to the number of medical schools, this evil will exist, for we cannot expect a school whose existence depends on its tuition fees to commit suicide to elevate the dignity of our profession.

How then shall the standard of medical education in this country be raised? I cannot presume to dictate, but will only offer a mode that is self-evident. As the the evil is two-fold, so must the remedy be. The laity must be educated more thoroughly in an appreciation of the highly educated medical man. We laugh at the superstitions of the middle ages, and yet we have almost as many around us to-day. Instances of this can be seen everywhere. In my own experience, I have seen men of education who habitually carried potatoes in their pockets to prevent rheumatism. Among the colored population, the belief in Voodooism is wide-spread, and is not a negligible factor in the treatment of their diseases. The veil of mysticism that sur-



round the physician and his work must be swept away, and the laity educated to an appreciation of his labors. The principles of hygiene should be taught in the public schools, and the reasons for them given so clearly as to be understood by all, for "the reason of the law is the life of the law," and unless the reason be seen, the laws of health will be but a senseless code of rules.

When we get an intelligent and appreciative body of laymen, we will find that it will no longer tolerate the half-finished product of many of our schools as at present managed. The low requirements for entrance and for graduation will have to be raised, and the American schools have it in their power to effect this renaissance of their own motion and not as the result of pressure from without.

The thought and services of the physician have been demanded by man ever since the primal curse of his race robbed him of immortality and condemned him to return to the dust of his genesis through a life of sorrow and suffering; yet thousands of years have not sufficed to separate the truths from the superstitions of pathology nor, in the minds of the public, to divorce the true physician from the quack or the conjurer.

Nor can it be said that the public has no grounds for some misgiving. Men still suffer and die, and physicians who have probed all that we have yet learned of human disease and of remedies, stand by the bed-side, helpless and hopeless. It is true that all men must die, but, as in the science of human rights, there is a remedy for every wrong, so somewhere in her great dispensary, perhaps, has Nature provided a remedy for every disease, and only waits for man to find out thoroughly what the disease is and how it is caused, that she may, in the plenitude of her mercy, banish pain and leave the physical man with no foe but the slow though sure attrition which, with advancing years, in obedience to the laws of God, wears away the strongest.

THE HISTORY OF SYPHILIS.

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Seven towns disputed about the birthplace of Homer, each claiming the honor. Three nations have disputed about the birthplace of Syphilis, each modestly declining the doubtful compliment of having inoculated the world with this *grosse verole*.

It was unknown in Europe prior to 1494. Toward the close of this year the armies of Charles VIII., King of France, invaded Italy and occupied Naples for a few months. Whether by coincidence or not, no one can say, but it was during this time that the new disease made its unwelcome appearance. The Neapolitans called it the "French Disease," and the invaders called the new comer the "Disease of Naples."

Again, another historical event is adduced to which some trace the origin of the disease. Columbus and his men, after their memorable first visit to America, which is to be duly celebrated in Chicago shortly, returned to Spain in 1493. In addition to the important historical and geographical achievement of discovering America, it is said that they discovered (*nolens volens*) something else over here which has never yet been of any manifest benefit to mankind. Their new find was syphilis, and along with other relics and treasures, they bore it back to the Old World, and industriously began the work of its rapid dissemination. In twelve months it had become an epidemic.

In the August issue of the *American Journal of Medical Science*, Dr. Hyde, of Chicago, contributes a paper on Pre Columbian Syphilis in America, in which the history of the disease is reviewed, and the theory of its American origin very ably discussed. A valuable contribution to this subject has been made by Prof. Joseph Jones (*New Orleans Medical and Surgical*

*Journal*, June, 1878), who examined the skeletons found in Indian mounds in Mississippi, Tennessee and Kentucky, and concluded that he had found the "most ancient syphilitic bones in the world." From etymological studies Dr. Bruhl, of Cincinnati, believes that the disease existed among the Indians before the advent of Spaniards.

Dr. Hyde has carefully examined some bones exhumed from mounds in Arkansas, California, Colorado, etc., and he notes that there is a "conspicuous absence of certain features which are to be expected in bone syphilis. There were no nodules, nor the circumscribed swellings at the distal extremities of syphilitic bones, nor circumscribed or diffuse gummatous involvement, nor bone cicatrices, nor localized sclerosis. Knowing nothing of therapeutics the aborigines would certainly have transmitted to their offspring unmistakable signs of the disease. Yet Dr. Hyde looked in vain for the lesions of inherited syphilis. He, furthermore, submitted two tibiæ to Dr. T. M. Prudden, of the laboratory of the College of Physicians and Surgeons, New York, for microscopical examination. Prof. Prudden concludes: "That the individual was not the victim of any phase of hereditary syphilis, which induced developmental malformations of these bones, is evident from the well formed articular extremities. On the whole, while I am disposed to think that there is nothing in the morphological condition of these bones which would forbid the assumption that the lesions might have been induced by the atypical form of syphilitic inflammation, they present, nevertheless, no morphological evidence to justify such a belief."

From the examination of bones, hitherto made, from the mounds of the Cave-dwellers of North America, it is "not proven beyond question that said bones are either syphilitic or prehistoric. And it is not difficult to conclude that positive proof of the prevalence of syphilis among the prehistoric races of America, based upon osseous changes, is scarcely yet at hand.

By all the preceding we are reminded of the remark of the great French wit: "Syphilis is like the fine-arts; we do not know the inventor of it."\*

*\*La verole est comme les beaux-arts; on ignore quel en a été l'inventeur.—Voltaire.*

## **Selections.**

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### **WHY SYPHILIS IS NOT ABORTED BY THE EARLY DESTRUCTION OR EXCISION OF ITS INITIAL LESION.**

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**By R. W. TAYLOR, M. D.,**

**Clinical Professor of Venereal Diseases at the College of Physicians and  
Surgeons, New York.**

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From a very early date the idea of aborting syphilis by various means was entertained by surgeons, and this idea has prevailed until the present day. Ten or twelve years ago excision of chancre, as a prophylactic measure, was largely practiced, and the communications are very numerous bearing upon the subject. The consensus of opinion among advanced syphilographers of to-day is that the operation is utterly futile. I have held for many years that the operation (useful in some cases as a therapeutic procedure) is utterly valueless as a means of destroying syphilis, and I have been searching for a long time the reason why.

The following personal case I will give with considerable detail, for upon it largely hangs the conclusions reached in this essay. On January 3, 1890, a gentleman came to me wishing to make an appointment for a date upon which I could circumcise him. At that time I made a preliminary examination of his penis, and on the free border of the prepuce I found a small, brownish-red, not excoriated, papule, no larger than the head of a small tack. It struck me instantly that he had a hard chancre, for I had many times seen almost precisely such an insignificant lesion develop into a true syphilitic sclerosis. The patient was positive that when he took his bath on the previous morning

there was no spot on his penis, and he thought there had been none in the evening. So circumstances seemed to warrant the view that it began in the night.

Upon questioning the gentleman I obtained the following facts: He lived in the suburbs of a large Southern city, and, as a rule, when he went to town he cohabited with a woman in some first-class house. He had been at his home, and had for a period of three months prior to December 20, 1889, been perfectly continent. On that date he went to the city, transacted business during the day, and passed the night in the embraces of a lady of the town, whom he had been assured was perfectly clean and healthy. He had no further sexual intercourse until the time of his first visit to me, just fourteen days after this last coitus. At the consultation I explained my suspicions, thus fortified by a very clear and conclusive history, and urged the operation, thinking in my own mind that if ever there was a favorable opportunity for testing the value of excision of chancre as a prophylactic for syphilis, this was the case. It so happened that business of importance delayed the operation until January 7th, four days after the appearance of the chancre, and eighteen days after the inoculation of the syphilitic infection. At this time no perceptible enlargement of the inguinal ganglia could be felt, a symptom looked for and also not found four days previously. The prepuce was removed, and, owing to its marked redundancy fully one and one-half inch of tissue was ablated. Healing took place promptly in a week, and no traces of induration were to be found in the cicatrix. Plenty of tissue remained to allow of full erections. The patient was watchful of himself and constantly came for inspection. On January 15th, I thought I detected slight enlargement of the inguinal ganglia; but on the twentieth of that month the adenopathy was very evident. From that date it increased until it became typical in all particulars. On February 21st, a typical roseola appeared, which had been watched for daily during the preceding fortnight. At this time the ganglia in the neck and at the elbows were perceptibly enlarged and typically syphilitic. Prior to the evolution of the secondary period of syphilis I found very minute but hard cords running up the dorsum of the penis. The nature of the excised papule was therefore proved beyond doubt, and I congratulated myself that

I had placed in a proper fluid for preservation and examination that redundant but precious prepuce.

These studies, therefore, go to show that in the very first days of syphilitic infection, as shown by the chancre after the first period of incubation, the poison is deeply rooted beneath the initial lesion, and that it extends far beyond it; that it is in a most active state, and, running along the course of the vessels, it soon infects all the parts beyond, even to the root of the penis. These studies seem to warrant the conclusion that the virus is not localized to its point of entry and that it does not shut itself in by throwing out a dense wall of circumvallation, which later on disappears and allows of the exudation of the morbid products of the heretofore supposed closed-in morbid focus. Clinical and pathological facts go to show that the infective process occurs very rapidly.

Ricord, in his later years, has said that he considered the destruction of the infecting chancre as absolutely useless (in a prophylatic sense), no matter how early it is done. That it is certain, even before its appearance, that syphilis exists, and that even if the entire penis should be amputated before the chancre showed itself, syphilis would follow nevertheless. This certainly is rather a broad statement, but in a measure it is warranted by the facts which have just been developed.

In this essay I have sought to show why syphilis is not aborted by excision of its initial lesion, with a liberal slice of the surrounding parts. The reason, succinctly stated, is, that (contrary to the present view) the syphilitic infective process is from the very start a quite rapid one. That the poison strikes directly for the blood vessels and causing there its peculiar changes, runs along them with astonishing rapidity. Thus it gains a foothold in parts beyond the reach of the knife, the caustics, or electrolysis. In fact, the tissues of the whole penis in very early syphilis are, we may say, honeycombed by these infected vessels. These observations just presented, backed by the evidence of the failures in chancre excision, go to show that beyond the chancre there is sufficient syphilitic poison to infect the whole economy, and that the initial lesion, though the visible and exuberant evidence of syphilitic infection, may be removed without in any way altering or modifying the course of the disease. It is rather too early to inquire into the *modus operandi* of the maturing syphilitic infection, but it seems probable that this vessel cell-growth goes on and on until the whole economy is involved, and that then the explosion occurs which we call the evolution of the secondary period of the disease.—*Medical Record*.

## Book Reviews.

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**TREATISE ON SURGERY.** By C. W. Mansell Mouelin, M. D. Fellow of the Royal College of Surgeons ; Surgeon to the London Hospital, etc. P. Blakiston, Son & Co., Philadelphia.

In preparing this work the author's wish has been to make it practical, and to give special attention to the question of treatment. He endeavors also to enforce the idea that the aim and object of modern surgery is to assist the tissues in their struggle against disease.

Special chapters are furnished by Mr. J. Hutchinson, Jr., on Diseases of the Eye and Skin ; by Mr. Mark Hovell, on Diseases of the Ear and Larynx ; and Mr. F. S. Eve, on Tumors.

The general pathology of surgical diseases is first discussed, constituting Part I, and this, in our opinion, is the most valuable portion of the book. It embodies the results of our latest acquired knowledge, as is shown by the statement, under *inflammation*—"mechanical irritants can only cause simple inflammation ; suppuration can not occur without pyogenic organisms ; and tubercle cannot break out without its specific bacillus."

For the remainder of the book, which relates to the diseases and injuries of special organs and structures, we fail to see that it is any improvement on many other good works on surgery. It contains some new matter, of course, for instance, a very good illustrated description of Charcot's disease ; but, for the most part, the subject is treated in the usual way. We doubt very much the propriety of attempting to include any longer in a work on surgery a discussion of skin diseases.

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**MINOR SURGERY AND BANDAGING.** By H. R. Wharton, M. D. Surgeon to Presbyterian Hospital ; Demonstrator of Surgery in the University of Pennsylvania, etc. Lea Brothers & Co. Philadelphia.

The first ninety-eight pages of this book are devoted to a description of the various kinds of bandages, and the application of bandages to different parts of the body. In Part II. is found a full discussion of the procedures embraced by the term, *Minor Surgery*. In this part the author very properly emphasizes the importance of asepsis and antisepsis. The treatment of fractures and dislocations, the ligation of arteries and amputations are disposed of in the usual way. The book is abundantly illustrated with excellent cuts, many of which we have seen before in other places. Dr. Wharton has done his work exceedingly well, and given us a "Minor Surgery" not excelled by any other.

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## Original Communications.

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### PUERPERAL INFECTION.—ETIOLOGY AND RESULTS.\*

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By R. R. KIME, M. D.,

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I have selected the term "puerperal infection," as used by Garrigues<sup>1</sup>, of New York, as more appropriate, definite and comprehensive than "puerperal fever," "septicæmia," "septic infection" and other terms that have been used to designate abnormal conditions occurring during the puerperium as a result of infection. We find the terms used interchangeably by different authors, as if they designated one and the same condition as to origin. In this article we shall consider all infections occurring

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\*Written for Tri-State Medical Association.

<sup>1</sup>Cyclopædia of Obstetrics.—Mann.



during the puerperal state under the general term of "puerperal infection," which may be divided into,

Puerperal infection	{	Putrid infection—mild cases.
		Putrid intoxication—severe cases.
		Septic infection—mild cases.
		Septic intoxication—severe cases.

As a basis for the above division of puerperal infection, we quote, "None of the pus-generating cocci cause what is commonly called putrescence."<sup>2</sup>

"Decomposition of tissues accompanied by the production of foul odors is always due to the fermentative action of divers forms of elongated bodies, called bacilli or bacteria."<sup>3</sup>

"The chief significance of the fungi *staphylococcus pyogenes*, *aureus* and *albus*, and *streptococcus pyogenes*, is that they give to pus a septic power, which pus free from these elements does not possess."<sup>4</sup>

"Koch inoculated mice with putrid blood and meat infusions, five drops usually killing the mice in four to eight hours. From examination he concluded the poisoning and death was due to a chemical substance called sepsin."

"Klebs differentiates between septicæmia and pyæmia, although he claimed that putrid intoxication and septic infection were the same. Koch injected mice with blood that had putrefied for a few days only; five drops killed in a short time. One minim often produced no morbid symptoms. One-third of the animals injected with one to two drops in twenty-four hours began to manifest morbid symptoms and died in forty to sixty hours; no inflammation at seat of infection; no bacteria in the blood or internal organs, and could not be transmitted to other mice by inoculation. While one-tenth drop of œdema fluid and blood from mice dying of sepsis produced same symptoms as in the putrid inoculations, and death. The virus could be transmitted and propagated indefinitely. Small bacilli alone appeared in the blood constantly and in large numbers."<sup>5</sup>

<sup>2</sup>Cyclopædia of Surg., Vol. 1, p. 92.

<sup>3</sup>Gerster.—Rules of Aseptic and Antiseptic Surgery.

<sup>4</sup>Wyeth.—Text-book on Surgery, p. 62.

<sup>5</sup>Senn's Principles of Surgery, p. 304.

"The general symptoms which accompany all suppurative affections represent, etiologically and clinically, a form of sepsis, which differs in its intensity according to quantity of pus-microbes, or their ptomaines, which reach the general circulation. Besser is of the opinion that the streptococcus of suppuration is the most frequent cause of sepsis."<sup>5</sup>

"From these considerations it becomes evident that the essential bacterial cause of septicæmia is variable, and that the disease represents a general febrile condition, which is brought about by the absorption from a local focus of different toxines from as many microbes. As the introduction into the circulation of the products of putrefaction is followed by a complexus of symptoms which closely resemble what is understood clinically by the term septicæmia, and as different microbes have been cultivated from septic patients, it would seem that the disease can be produced by any of the microbes which, after their introduction into the organism, have the capacity to produce a sufficient quantity of phlogistic ptomaines to give rise to septic intoxication. Septic intoxication is caused by the absorption of a pre-formed ferment or toxine, which produces the maximum result as soon as it reaches the circulation, and the symptoms subside with the arrest of further supply and elimination of the septic material from the circulation.

"Septic infection, on the other hand, occurs in consequence of the introduction into the circulation of living micro-organisms which multiply with great rapidity in the blood, a circumstance which imparts to this form of septicæmia its progressive character."

"In 1857 Pasteur made the important discovery that specific micro-organisms are the cause of the various forms of putrefaction and fermentation."<sup>6</sup>

"Sapræmia is the typical form of septic intoxication and never occurs without putrefaction of necrosed tissue, which never occurs without infection by putrefactive bacteria. The bacilli of

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<sup>5</sup>Senn's Principles of Surgery, p. 312.

<sup>6</sup>Senn's Work, p. 319.

putrefaction exercise their pathogenic qualities only in dead tissue exposed to the atmospheric air."<sup>7</sup>

"Fetor is associated with putrefaction, and as such is suggestive of sapræmia, and not true of progressive sepsis; the most fatal form of sepsis occurs without fetor.

"Septic intoxication invariably requires three conditions, (1) dead tissue; (2) infection of this dead tissue with putrefactive bacteria; (3) a sufficient length of time must have elapsed since the injury or operation for the putrefactive bacteria to produce a toxic quantity of ptomaines to cause symptoms of intoxication."<sup>8</sup>

"Blumberg also confirms the statement that the blood of patients dying of putrid intoxication contained no micro-organisms."<sup>9</sup>

"Semmer, commenting on experiments of Guttman of Dorpat, claims that a chemical poison is developed in putrefying substances, which, in sufficient quantity, produces symptoms of sepsis and death in animals. The blood of such animals possesses no infective qualities, bacteria being destroyed in the blood to appear after death. True septicæmia is always preceded by a stage of incubation, and its contagium is destroyed by boiling, *putrefaction* and germicides."<sup>10</sup>

Fränkel also confirms the statement that putrefaction destroys septic microbes. Brieger and Maas have rendered valuable service in the chemical isolation of ptomaines, or, as Brieger calls them, toxins, from putrid substances, and the results of their inoculation experiments established more firmly the fact of putrid intoxication by these alkaloid substances.

"Prof. Vaughan, Ann Arbor, divides bacteria into toxicogenic and non-toxicogenic. He further states we know of no infectious disease in which poisons are not formed, hence the toxicogenic germs only are of interest to us."<sup>11</sup>

<sup>7</sup>Senn's Principles of Surgery, p. 315.

<sup>8</sup>Senn's Principles of Surgery, p. 322.

<sup>9</sup>Senn's Principles of Surgery, p. 320.

<sup>10</sup>Senn's Principles of Surgery, p. 319.

<sup>11</sup>Ptomaines and Leucomaines (Vaughan), p. 13.

"Leucomaines are 'animal alkaloids,' those basic substances which result from tissue metabolism in the body."<sup>12</sup>

"Gautier includes under the name leucomaines all those basic substances which are formed in animal tissues during normal life, in contradistinction to the ptomaines or basic products of putrefaction."<sup>13</sup>

"Ptomaines are transition products in the process of putrefaction. They are temporary forms through which matter passes while it is being transformed, by the activity of bacterial life, from the organic to the inorganic state, . . . p. 16. All putrefaction is due to the action of bacteria; it follows that all ptomaines result from the growth of these micro-organisms. The kind of ptomaine found will depend on the individual bacterium engaged in its production, the nature of the material being acted upon, and the conditions under which the putrefaction goes on, such as the temperature, amount of oxygen present and the duration of the process."<sup>14</sup>

"Brieger points out that a certain quantity of oxygen is necessary to the formation of poisonous bases. A free supply of oxygen on the other hand, invariably yields non-toxic ptomaines. The poisonous bases begin to appear on about the seventh day of putrefaction, and in turn disappear, if this is allowed to go on for a considerable length of time."<sup>15</sup>

"The origin of leucomaines is indissolubly connected with the metabolism of the cell itself, and they are therefore, found in the tissues and organs proper, especially those rich in nucleated cells."<sup>16</sup>

From these quotations, which we have collected, representing the advance thought of the day in regard to the pathogenesis of infectious diseases, and the development of toxins, more prop-

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<sup>12</sup>Ptomaines and Leucomaines (Vaughan), p. 15.

<sup>13</sup>Ptomaines and Leucomaines (Vaughan), p. 280.

<sup>14</sup>Ptomaines and Leucomaines (Vaughan), p. 17.

<sup>15</sup>Ptomaines and Leucomaines (Vaughan), p. 187.

<sup>16</sup>Ptomaines and Leucomaines (Vaughan), p. 280.

erly called ptomaines and leucomaines, we shall endeavor to present some conclusions based upon the facts quoted:

1. That puerperal infection is not due to one cause or specific micro-organism, but may be produced by the action of a variety of micro-organisms or by the effects of their alkaloidal developments.

2. That *puerperal infection* is never autogenetic but always heterogenetic in origin, either directly or indirectly.

3. That the term *puerperal septicemia* should be applied only to puerperal morbid conditions due to entrance and multiplication of living microbes with development of leucomaines in the generative organs of the female and then entering the blood, producing local and systemic effects.

4. That *septic intoxication* should be used only to designate a super-saturation by septic microbes and their alkaloidal development, *i. e.*, leucomaines. According to the common acceptance of the meaning of *intoxication*, it should express in this connection, an overdose of sepsis.

5. That *putrid infection* should be used to designate the morbid condition resulting from the absorption of ptomaines developed by putrefactive bacilli.

6. *Putrid intoxication* should indicate the absorption of an excessive amount of putrefactive chemical products called ptomaines.

If the experiments and bacteriological researches cited in this paper are demonstrated facts, I cannot conceive how the terms *septic and putrid infection*, *septic and putrid intoxication*, can be used so indiscriminately, when we consider them in a causative relation as etiological factors in the production of puerperal complications. It is true, with our present knowledge, that it is very difficult, even impossible, in some cases to differentiate these conditions clinically, yet etiologically considered there is certainly a difference. To make this difference apparent and express it briefly, we will present in contrast some of the essential points between

## SEPTICÆMIA

## and

## PUTRID INTOXICATION.

Due to entrance and multiplication of *microbes* and development of *leucomaines*.

Due to germ life and its reproduction.

Contagious.

Inoculable from case to case.

Blood contains germs similar to those introduced.

May be produced by various germs.

May be produced by the fraction of a drop of the virus containing septic germs.

May be produced by the virus from the exanthematous fevers.

Erysipelas.

Surgical fever.

A previous septic case.

Gonorrhœa.

Due to absorption of putrefactive *alkaloids* called *ptomaines*.

Due to absorption of chemical products.

Not contagious.

Not inoculable.

Blood does not contain germs.

Produced by *ptomaines*, the result of putrefactive bacteria only.

Requires absorption of sufficient chemical products to produce toxic effects similar to toxic doses of poisonous medicines.

Never.

Never.

Never.

Never.

Never.

While dealing with the subject of *puerperal infection* I desire to present gonorrhœa as a causative factor in producing septicæmia, and hope to elicit discussion that will shed some light on this important question. Is it possible that gonorrhœa can produce such serious conditions of the female generative organs at other times and be devoid of influence during the puerperal state?

It cannot be successfully denied that puerperal infections are more common in the private practice of city physicians than in those practicing in the country. While a want of development of the female in the city, dress and society customs combine to produce such a result, gonorrhœa certainly plays an important part in maintaining this difference. If gonorrhœa can, under ordinary circumstances, produce endometritis, salpingitis, ovaritis, often pyosalpinx and secondarily pelvic peritonitis, then what should we expect from the presence of gonorrhœal virus and its results during abortion and labor?

If the gonococcus is not destroyed at these times by antiseptic precautions, it would certainly, at least favor the development of pelvic cellulitis, pelvic peritonitis or salpingitis, with pyosalpinx, which are so often found by the gynecologist.

If gonorrhœal infection occurred previous to pregnancy from a partially cured, latent gonorrhœa in the male, which invades

tissues slowly for want of activity of the virus and involves one tube, pregnancy occurring before the other tube becomes involved would favor puerperal complications.

The physiological development of the tube during pregnancy certainly furnishes a congenial soil for the development of the gonococcus and its results. Pus forms in the tube, labor occurs, and what may happen especially if the abdominal extremity of the tube be permeable? Again, suppose the gonorrhœal virus be introduced a short time previous to abortion or labor, finding lodgment in the vaginal canal and after the uterus is emptied, proceeds to invade new territory, what result should we expect?

If pus tubes occur so frequently after abortion and labor, as stated by gynecologists, there is certainly some cause for it outside of the mere process of emptying the uterus of the products of conception. I am satisfied that one of the most potent causes of this difference is gonorrhœa. If not, why are so many pus tubes found following abortion and labor occurring in the city and so few occurring in the country. No one should doubt the greater frequency of gonorrhœa in the city.

To illustrate: "Sänger, of Leipsic<sup>17</sup>, found a purulent discharge in 100 out of 389 pregnant women, 26 per cent., and forty of the children ultimately born had ophthalmia neonatorum."

O. Oppenheimer, of Heidelberg<sup>18</sup>, found the specific diplococcus in thirty out of 108 pregnant women, 27.7 per cent., and ophthalmia neonatorum occurred in 12 to 13 per cent.

Somer, in Schröder's clinic, of Berlin, found the specific diplococcus in nine out of thirty-two pregnant women.

Barton Cook Hirst, under "Complications of the Puerperal State," says: "The poison of gonorrhœa can, without doubt, excite inflammation of the deeper tissues in this region, and is quite certain if it spreads through the tubes to light up a sharp attack of peritonitis. The diagnosis can of course be made with approximate certainty if the disease existed during pregnancy, or if a careful examination detects an inflammation of the urethra and the vulvo-vaginal glands, or if it is possible to isolate the gono-

<sup>17</sup>Gonorrhœa in Women (Sinclair, W. J.), p. 283.

<sup>18</sup>Gonorrhœa in Women (Sinclair, W. J.), p. 283.

coccus. The consequences of gonorrhœa in the puerperal state can be of the most serious nature. There may be a rapid accumulation of pus in the tubes in the course of this disease during the puerperium."<sup>19</sup>

It is evident that puerperal infection is not always due to one and the same germ nor one and the same cause.

We may have puerperal infection from death, retention and decomposition of the foetus *in utero*; concealed hemorrhage with retention and decomposition; retention, decomposition and absorption from any of the products of conception after abortion or labor; *also in those cases where a cough immediately follows delivery, where genitalia are not kept properly cleansed and disinfected*; besides the ordinary channels of infection from physician, instruments or nurse, and in those cases in which the virus exists in the genital canal previous to parturition. Some of these conditions would seem to be autogenetic in origin, but not so. The dead foetus, concealed hemorrhage, retained maternal or foetal structures cannot of themselves infect the patient until changes take place in them not wrought by powers inherent to themselves nor generated by the mother, but originally received from other sources. This is also true of gonorrhœa and pyosalpinx as etiological factors, for the infectious virus was originally generated elsewhere and transmitted to the mother.

Puerperal infection may be divided into two general classes as to contagiousness or transmissibility from case to case. It is certainly an axiom that those cases due to the entrance of septic germs and their development in the blood and various organs of the body are contagious, transmissible and may be easily conveyed or inoculated from case to case.

Not so with those cases due to a chemical product, the result of putrid decomposition. Such cases are not inoculable or transmissible from case to case, only when a sufficient amount of the chemical product of decomposition—ptomaine—is transmitted to produce its effects the same as a toxic dose of poisonous medicine. It may be indirectly transmissible by conveying the vagi-

<sup>19</sup> Am. Sys. of Obstetrics, p. 522.



nal secretions from a case of putrid intoxication to the vagina or uterus of a recently delivered woman where the uterus or vagina contains dead foreign material, thus instituting putrid decomposition of such retained material, developing ptomaines, which are absorbed, affecting the patient.

Hence the necessity for strict cleanliness under all circumstances, and under some conditions the almost imperative demand for *antiseptic precautions*. The physician is not responsible for all cases of puerperal infection, but for a majority at least, and should use all reasonable, rational means at his command to prevent infection.

If our basis and conclusions be correct as to the etiology and transmissibility of puerperal infection, then such expressions from a physician in active obstetric practice for ten or fifteen years, "I never have any cases of puerperal fever," is but the *confession of ignorance or a misstatement of the facts*. It is but another example of the obstetrician who, in fifteen or twenty years' practice, never encountered a lacerated perineum, while the gynecologist was continually following his work repairing the perineum. So to-day the gynecologist is often called upon to treat the results of puerperal infection. Some physicians never have a case of puerperal infection until their patient dies, and then the death certificate records a death from "inflammation of the bowels," "malarial fever," "typhoid fever," etc., etc.

The mortuary statistics on this subject are very unreliable as a rule, and worth but very little from a scientific standpoint. The idea becoming prevalent among the profession and the laity to a great extent that the physician was responsible for all cases of puerperal infection occurring in his practice, the physician, as a natural result, would use his diagnostic skill to class all such cases under some name for which he would not be held responsible. Then again the death rate thus reported has been taken as a guide to the number of cases of puerperal infection occurring, and as an *indication or contraindication* for the use of *antiseptics*.

In an article read before the Indiana State Medical Society in 1888 by Dr. L. N. Davis, on the "Obstetric Record of the

Country Doctor," we find a record of 3,752 cases of obstetrics, with only seven deaths from "puerperal fever."

Dr. G. W. H. Kemper reported next year 900 cases, with no deaths from "puerperal fever," thus making 4,652 cases, with seven deaths, or one in every 665 cases. "No antiseptic precautions taken in the practice of these physicians," so reported. It is not my province to call in question these statistics, as they are vouched for by *competent, honorable* men, especially Dr. G. W. H. Kemper, an ex-president of the Indiana State Medical Society. They undoubtedly show an excellent record, and lead us to inquire why this difference between city and country obstetric practice? The record of these six physicians, whose ability would render them competent to conduct labor aseptically, if not antiseptically, should not be taken as a correct guide as to the death rate in country practice, where all classes of physicians attend cases of labor.

I wish to offer a protest against making the death rate a basis on which to calculate the number of cases of *puerperal infection*, or as an indication or contraindication for the use of *antiseptic precautions*. When we recognize that puerperal infection may produce any of the following named conditions, vulvo-vaginitis, endometritis, salpingitis, uterine lymphangitis (most frequent condition resulting from infection), peritonitis (pelvic and diffused), adeno-phlegmon (inflammation of lymphatic glands and surrounding connective tissue, called pelvic cellulitis and parametritis), and phlebitis (adhesive and infectious); that any of these conditions may be produced in a light or severe form according to amount, quality and activity of virus introduced, as well as the condition of the patient and organs infected; that the infecting virus may be developed from such a variety of sources, and conveyed in so many different ways, as previously alluded to in this paper; that the effects of infection are not always wrought immediately, but often result in subinvolution, inflammatory deposits, fixation of uterus and appendages in abnormal positions and pyosalpinx. Then we are in a condition to fully realize the import of the term *puerperal infection*, and see the necessity of adopting means to prevent these various conditions, originating primarily from so many various sources.

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## ELECTROLYSIS FOR THE DESTRUCTION OF HAIRS AND MOLES.

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### CASES.

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By M. B. HUTCHINS, M. D.,  
Lecturer on Dermatology, Atlanta Medical College,  
Atlanta, Ga.

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About ten years ago Dr. Michel, of St. Louis, reported successful results of electrolysis in the treatment of trichiasis. Dr. Hardaway, of the same city, deserves the credit of applying the same measures to the treatment of growths of superfluous hairs, as met with in the practice of dermatology. The following case from my practice may prove of interest :

### HYPERTRICHOSIS.

Mrs. ———, age 43, consulted me on October 30, 1890, with condition to be described :

Several large, dark moles on lower half of face. Growing in these, numerous long hairs, from almost colorless to deep black in shade. On each angle of chin others were present, quite abundantly, and there were also many finer and paler hairs over the chin. Quite a decided growth on upper lip, especially near the corners of the mouth, where they were coarse. Those in the moles and on the chin were more or less curled or twisted from the patient's efforts to make them "lie down." She thought increased growth resulted from pulling the hairs out.

History of keloid on chest from caustic application. This was excised eighteen months previous, and the site of the majority of the stitches was marked by hypertrophic scar tissue. This tendency to so-called "false keloid" warned me that the use of the electrolytic needle would have to be very cautious, otherwise we might get a lot of these growths at the points operated upon.

The first operation was done December 12th, about six weeks later. Having no miliamperemeter, it was necessary to estimate the current of electricity by "cells" alone. A Kidder battery

was the first used, five cells furnishing sufficient current. To the positive pole was attached an ordinary sponge electrode; to the negative a pencil-shaped needle holder containing a fine sewing needle—which answers every purpose. Upon this holder was a spring, which had to be pressed down to complete the circuit through the needle. At first this spring was bound down and the circuit completed or broken simply by letting the patient take hold of or let go the sponge electrode. Later it was found best to let the spring regulate the circuit, the patient only letting go the sponge in order to wet it. (The *negative* pole is the one to which to attach the needle, because, if it were attached to the *positive*, a black point, as will be seen later, would result from the chemical action taking place.)

The sponge electrode was kept well wet with water from a basin near. Before completing the circuit the needle was gently inserted by the side of and in the direction of the hair (they do not grow straight out—perpendicular to the skin) until a faint resistance, the “bottom” of the follicle, was felt. Completion of the circuit was followed by a little frothing around the point of the needle, this being the more marked where the needle had penetrated exactly to the “bottom” of the follicle. After fifteen seconds to probably a minute the circuit was broken and traction made upon the hair with forceps. If it came out easily, we could be sure the papilla was destroyed and that another hair would not grow. If the hair proved hard to extract, the needle was re-inserted and the current again applied. It was noticed that there was less pain when the needle was properly inserted, but at best it is rather suggestive, at first, of a bee sting. The pain, however, is only at the instant of completion of the circuit, and there follows a somewhat benumbing secondary effect. The punctured skin became red and tended to form mosquito-bite-like lesions. For the purpose of relieving the irritation, the following was applied at intervals, both during and after the operations:

R. Zinci oxidi pulv., ʒi.  
Ether. sulph., ʒii.  
Aquæ, ʒvi.

M. Sig: Shake and apply.

On December 12th ten hairs were removed, and twelve the next day. The patient returned to her home, out of the city, and the next *seance* was not until February 23, 1891. (It is said that ten per cent. of the hairs will return, but I think our percentage was much lower than that.) This time I used a borrowed battery, and made the mistake of attaching the needle to the *positive* pole, thus producing a *black point*. The needle was immediately changed to the *negative* pole. Six cells first used, then eight. On February 23d, removed twelve hairs; on the 24th, sixteen, using only six cells; on 25th, fifteen removed, and the large mole on right side of chin was transfixed with the needle twice, the punctures at right angles to each other, six cells. Some hairs in the moles were directly operated upon, while others were left, to see if the operation on the moles would cause the hairs to be destroyed. It was found, later, that some *were* thus destroyed. During the passage of the current through the moles, they changed from dark brown to yellowish white. On February 27th five hairs were removed, using six Law cells, sal ammoniac charge.

Next *seance* March 21. Twenty-one hairs removed, six Law cells. Moles not much smaller. Black point treated with needle from negative pole to see if a reversed chemical action would cause its disappearance. A lotion of oxide of zinc, subnitrate of bismuth, alcohol and water was now being used for the soothing effect. March 23d, twenty hairs from chin. No large, black ones remained. On 24th, ten small hairs from chin, and five, large, from each "side" of upper lip. Mole right side again treated. On 25th, five each side of lip. Black point again treated. On May 13th, 14th and 15th other operations; larger hairs on lip, smaller on chin. Moles disappearing, but patient had rather given up the idea of having them further treated. On September 7th and 8th the work was completed, only a few fine, lanugo hairs remaining on lip and chin. From the removal of ten at the first sitting, the patient gradually reached the ability to stand from forty to fifty being removed at a time. The re-growths which took place during the intervals amounted practically to *nothing*. At last operation the black point had entirely disappeared.

When one undertakes to count hairs he is going to be very much surprised at how far the number exceeds his estimate. I found it so in this case. There did not seem to be *many*. From the chin one hundred and eighty-five (185) were removed. From the upper lip one hundred and sixty-seven (167). From face, neck and "scattering," twenty-eight (28). Total 380.

Sufficient time has elapsed to justify the belief that the operation will prove a complete success.

#### MOLES.

The effect of only a few applications of the current to the moles in the above case proved that they could have thus been destroyed. Three cases were treated by electrolysis, but two of them did not continue the sittings, only attending once for treatment.

Case 1.—Mr. —, age 21. Just above and to the right of the upper lip a round, pinkish, solid growth the size of an English pea. Present all his life. The mole was pierced nearly through its base, transversely, with a large spear-pointed copper needle and a current of ten cells used. Then the needle was reinserted at a right angle, transversely, to first puncture and the same current employed; current each time allowed to pass for about thirty seconds. Some blanching of the mole and considerable frothing along the course of the needle were produced by the action of the current. Pain was only moderate and temporary.

A week later the growth seemed a little smaller, and sensation was much blunted. The current from eight cells now used through a small sewing needle. Frothing around needle as at previous sitting. Twelve days later all that remained of the growth were two small pin-head sized dark elevations. There was no further treatment, as they gave promise of gradual disappearance of themselves.

Two other cases were similarly treated, but the result is not known. The growth in one of these cases had partially declined after the use of electrolysis a year previous.

1 ½ *Edgewood Avenue.*

## Society Reports.

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### SOUTHERN SURGICAL AND GYNECOLOGICAL ASSOCIATION.\*

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FOURTH ANNUAL MEETING, HELD IN RICHMOND, VA., NOVEMBER 10, 11 AND 12, 1891.

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#### FIRST DAY—MORNING SESSION.

The Association convened in the hall of the Young Men's Christian Association, and was called to order by the President, DR. L. S. McMURTRY, of Louisville, Ky., at 10 A. M.

Prayer was offered by the Rev. D. M. Hoge.

The first paper read was by Dr. J. W. Long, of Randleman, N. C., entitled

#### ALBUMINURIA; ITS RELATION TO SURGICAL OPERATIONS.

He drew the following conclusions:

1. That either ether or chloroform rarely ever injures healthy kidneys.
2. That when renal disturbances from the use of an anæsthetic, the kidneys being healthy, do occur, they are due rather to prolonged narcosis, exposure of the patient, or perhaps to the combined influences of the operation and the anæsthetic.
3. That a mild degree of albuminuria or nephritis, especially if recent, is not a contraindication to the use of chloroform or ether.
4. That even in the presence of advanced and extensive renal changes, an anæsthetic may be employed, provided the patient or family are advised of the additional risk.
5. That of the two anæsthetics usually employed, it is yet a mooted question as to which is the safer so far as the kidneys are concerned, unless it be in obstetrical operations.

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\*Received too late, and crowded out of December issue.

6. That, while it is by no means the rule, profound functional disturbances and even organic lesions may be induced by an operation, apart from the influence of the anæsthetic.

7. That such renal changes are due to reflex sympathetic action or sepsis, or both.

8. That operations in certain regions, notably the abdominal, genito-urinary, about the mouth and rectum, are especially liable to produce renal complications.

9. That a healthy condition of the kidneys, minimizes, but does not obviate, the dangers referred to.

10. That albuminuria is always indicative of renal lesions, and should be regarded with distrust; but is not a positive contra-indication to an operation.

11. That when albuminuria is associated with other evidences of advanced renal changes, no operation should be undertaken without first candidly stating to the patient, or friends, the dangers incident to the condition of the kidneys.

12. That paradoxical as it may seem, an operation will sometimes relieve an albuminuria due to acute affections.

13. That no surgeon is justified in undertaking an operation without first knowing the state of his patient's kidneys.

#### SYSTEMIC INFECTION FROM GONORRHOEA.\*

DR. BEDFORD BROWN, of Alexandria, Va., read a paper on this subject.

DR. J. EDWIN MICHAEL, of Baltimore, Md., read a paper entitled

#### A REPORT OF SOME ADDITIONAL CASES OF EXTERNAL PERINEAL URETHROTOMY WITHOUT A GUIDE,

in which he said that the operation is one of great value, both in gonorrhœal and traumatic cases, and he thinks one is justified in bringing forward any experience in it which may be of use to the profession. His results were very satisfactory, a fact which he attributes rather to the fortunate circumstances that his patients were largely free from grave constitutional disease than to any

\*See page 607, December issue.



method or application which he had to suggest. He had simply followed what he considered the precepts of good surgery as applied to this region of the body, viz., free incision, free drainage, and as much of antiseptic surgery as the circumstances would allow.

The report of these eight cases brings up the number of patients on whom he made the operation of external perineal urethrotomy to seventeen, and the conditions which made the operation necessary include nearly all those which ordinarily indicate it. None of the patients have died at a period nearer than six months to the time of operation, and the deaths which have occurred were due to other causes. In the spring of 1887 he reported nine cases of perineal section without a guide, and he had only to add to the remarks made at that time, that increasing experience leads him to have more and more confidence in the good results of opening the perineum and less fear of danger.

It is true that he had had unusual good fortune in operating on cases which as a rule presented no grave kidney lesion, but while it must be admitted that such complication adds to the risk of the operation as much if not more than it does to others of equal gravity, he is firmly convinced that opening the perineum in old stricture cases with bad kidneys is much freer from danger than internal urethrotomy or even dilatation. A case in point: About ten years ago he did an internal urethrotomy on a patient with an old, tough stricture. In forty-eight hours he had a temperature of 107-8, and was very ill. The same patient returned to him a short time since. He could pass a No. 10 E. sound with difficulty. The stricture was resilient and closed after the sound to such an extent that urination was difficult and unsatisfactory. The patient had been having chills, and was somewhat nauseated and weak. His urine, although ammoniacal and ropy contained no evidence of grave kidney trouble. He proposed a combined internal and external urethrotomy, and refused to do either operation without the other. The patient consented. He opened the perineum freely and cut the urethra with the Otis instrument to 40 E. The temperature did not rise above 100°, the patient did well in every particular, and in three weeks he sent him home, passing a No. 36 F. instrument on himself.

## FIRST DAY—AFTERNOON SESSION.

DR. W. F. WESTMORELAND, of Atlanta, Ga., read a paper entitled.

## REDUCTION OF DISLOCATIONS BY MANIPULATION.

DR. JOSEPH PRICE, of Philadelphia, Pa., followed with a paper on

## COMPLICATIONS IN PELVIC SURGERY, AND HOW TO DEAL WITH THEM.

The author's reasons for choosing this subject were that the importance of recognizing the part that complications play in the work of the surgeon is not appreciated by the generality of medical men, by general surgeons, and least of all, by the tyro in surgery, and by those who are anxious to begin their surgical investigations and trial-trips by an entrance into the domain of abdominal or pelvic surgery. The complications in this special branch of surgery are primarily those of surgery in general, with many things superadded to render them formidable. It may be the intention of the surgeon to remove the appendages for a bleeding fibroid. In ordinary operations the removal of the uterine appendages is to the skilled abdominal or pelvic surgeon one of the simplest of undertakings. If, however, he attempts to accomplish their removal without holding in mind the complications that as a rule exist, or if he is a neophyte or an experimental dabbler, he will find too late in many cases, that he has attempted an operation that he cannot finish, or if he does complete it, he has also sacrificed his patient, or rendered her worse off than before. In other words, to accomplish a cure, he must abandon removal of the appendages and perform hysterectomy, which has but little in common with the operation originally proposed. If this idea is still further carried out, we shall find that complications do not confine themselves to one system of organs, but extend to all surrounding structures by reason of inflammatory adhesions. This is true of the bladder, ureters, intestine, omentum, stomach and liver. Adhesions are the bane of abdominal and pelvic surgery, and hence

we see that the greatest mistakes and failures are made by those who, from a knowledge of abdominal surgery simply, have attempted to deal with pelvic inflammations. The abdominal surgeons who can be counted as really successful pelvic surgeons are therefore few. This is said with no intention of detracting from the importance of abdominal surgery. The strictly abdominal organs must always enter largely into the domain of surgery.

With regard to irrigation, we must get out of our heads the idea that it is dangerous. Too often in the writer's experience has hot water brought about a speedy reaction in patients whose lives were almost despaired of. We are told that cases do not need flushing, that they do badly under it. Dr. Price believes that they do need flushing if they are desperate cases, and if they do badly they do so not on account of the flushing, but because of the operation that preceded it. Next we have a resort in packing. Guaze packing accurately applied to the bleeding or oozing surfaces, so that it can be removed without interfering with the otherwise complete operation, is of infinite value in hemorrhage. It can be suffered to remain indefinitely almost, broadly speaking, at least, up to sixty or seventy hours, if absolutely clean and fresh, either salicylated or iodoformized. The drainage tube controls hemorrhage. The drainage tube is currently spoken of as if it were an annex to pelvic surgery, easily dispensed with. The writer uses it almost without exception in adhesion. His results are better than those obtained without its use.

The plea of the paper was for absolutely exact, painstaking work, that shall leave nothing for regret, nothing to do over, nothing to explain, but shall stand out in the light of results as justifiable, scientific and perfect, when put beside methods that palliate without curing, and are no more a part of real surgery than is hypnotism refreshing sleep.

#### LAPAROTOMIES PERFORMED DURING THE PAST YEAR.\*

This was the title of a paper read by Dr. Thomas Opie, of Baltimore, Md.

\*See page 577, December issue.

DR. CORNELIUS KOLLOCK, of Cheraw, S. C., read a paper entitled

OVARIAN CYSTS, WITH THE REPORT OF A CASE OF OVARIOTOMY  
IN A YOUNG GIRL.

He said the causes of ovarian cyst seemed to be still a question *sub judice* in the minds of those who are most progressive, and who have made the greatest advancement in the science of gynecology. Various theories have been put forth by those of larger experience, who are earnest seekers after truth, and who are patient investigators of all unnatural and morbid phenomena. But no satisfactory decision has been obtained from all the patient and searching investigations that have been made as to the cause of this singular, unaccountable and sometimes fatal neoplasm, characterized by histological diversity from the viscus of which it is a production. Some of the theories seemed, at a glance, to be plausible, but upon close study we find they will not bear inspection.

CASE.—Miss C. L. H., aged 11 years, 8 months and 19 days; general health perfect in every particular. Menstruation first appeared about two months before she was 11 years of age, and continued with perfect regularity, never excessive or scant, nor was it accompanied by the slightest pain. Her physique was fine in every way. Though less than 12 years of age, she weighed 135 pounds; was strong and active. Her breasts were as full and large as those of a woman at 35. She was very handsome, had a fine voice and sang beautifully. She was very intellectual, and stood at the head in all her classes in a large high school. I saw her for the first time on the 9th of January, 1891. The abdomen was greatly distended, but facies ovariana was not very pronounced. I was confident she had an ovarian cyst, and I rather suspected she had two. On the 16th of January I made a section about three inches below the umbilicus and removed a cyst from each side, the one on the left weighing twelve pounds and that on the right seven pounds. A more prompt and complete recovery the writer had never seen from the simplest operation. Union by first intention took place, and

the sutures, silver wire, were removed at the end of the 7th day. In twelve days she was up and about her room, and on the 23d day after the operation returned to her home, a distance of 200 miles.

It is now ten months since double ovariectomy was done on this young girl, and there has not been the slightest discharge from her of any kind. At each menstrual period there is considerable commotion in the pelvic region, attended with some uneasiness in the head and back, but at each period these symptoms decreased, and the last two were accompanied by no pain whatever. The remarkable physical development in this case still continues. It is now ten months since the operation. She has regained six pounds in weight, weighs 141 pounds and looks better than before she underwent ovariectomy. This young girl came from the purest and healthiest stock of people in this region. Not an individual on either side was ever known to have any constitutional trouble of any kind. Her mother and family physician, both highly intelligent, say they never knew her to be the least indisposed in any way.

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#### SECOND DAY—MORNING SESSION, NOVEMBER 11.

The Association was called to order by the President at 10 o'clock.

Prayer was offered by the Rev. Dr. Newton.

DR. THOMAS J. MOORE, of Richmond, delivered an eloquent Address of Welcome.

DR. WILLIAM WARREN POTTER, of Buffalo, New York, read a paper entitled

#### A MEDICO-LEGAL ASPECT TO PELVIC INFLAMMATION,

in which he said that pelvic inflammations in women have been described, discussed and debated from almost every point of view imaginable, until our periodical medical literature is flooded with articles on the subject, and medical society transactions are teeming and bristling with papers pertaining thereto. So far,

however, he had not observed that any one had undertaken to discuss these intra-pelvic conditions from a medico-legal standpoint. It was his purpose to present that aspect of the question, taking for his text a case that developed an interesting problem in that respect.

After giving a history of the case, Dr. Potter emphasized the following points:

1. The intimate anatomical relations between the pelvic organs and the larger joints of the lower extremities, especially the hip and knee-joints, render them liable to reflexes.
2. The importance of careful diagnosis at the outset lest grave errors and possible disastrous consequences may result from treatment.
3. The medico-legal bearing that errors of judgment in diagnosis and treatment may have in relation to the patient, as well as upon the reputation of the physician.

#### THE MEDICO-LEGAL ASPECT OF INTESTINAL SURGERY.

DR. JOHN D. S. DAVIS, of Birmingham, Ala., read a paper on this subject. He said many physicians and surgeons who condemn all mechanical aids for intestinal repair know not how to use them; never saw them used; refuse to indorse a resection for gunshot or stab wounds; have been known to go in the witness-box for purposes of condemnation and disproof when they knew no more about intestinal surgery than a wild Indian about school teaching.

In this day of specialties in medicine, but few general surgeons have either the appreciation, opportunity or disposition to qualify themselves as expert operators in intestinal surgery, but many, to the discredit of the profession, voluntarily appear in the criminal courts of the country pretending to be such, wise and proficient. One of the greatest professional sins of the day is perverted knowledge or conceited ignorance. It is too often that physicians and surgeons weaken and invalidate their opinions to a greater or less degree by unscrupulous interest in behalf of those employing them, a fact cunningly turned to

advantage for defendants in criminal prosecution, and for like reason may become dangerous to the operators they oppose and envy.

To be able to do a laparotomy for stab or gunshot wounds of the intestines, inflicted by one with murderous intent, and be able to evade civil and criminal liability, the operator must (1) be able to show evidence of ordinary surgical knowledge in the requirement of the special operation to be performed; (2) he must possess ordinary surgical ability for doing the special operation to be performed; (3) he must exercise ordinary prudence in performing the special operation to be done, as to time, place, antiseptics, asepsis, assistance, nurses and after-treatment; (4) he must perform the special operation in an ordinary skillful manner. Hence, to prevent confusion, it will be good, if possible, to determine what constitutes ordinary surgical knowledge, ability, prudence and skill. Upon these depend the whole medico-legal status of the intestinal surgeon, and upon which the expert should be required to depend also. According to the practices and rulings of courts in this country the word *ordinary*, in its surgical adjectiveness, means that the surgeon shall be capable of and exercise that surgical knowledge, ability, prudence and skill with which a fair proportion of the surgeons of his given locality are endowed, and not that of the highest lights of his profession.

DR. JOHN A. WYETH, of New York City, made some remarks on

#### ETHER ANÆSTHESIA.

DR. HOWARD A. KELLY, of Baltimore, Md., followed with a paper entitled

#### HAND DISINFECTION.

DR. I. S. STONE, of Washington, D. C., read a paper on the

#### PEDICLE IN HYSTERECTOMY.

The principal methods were described and illustrated by colored drawings, showing the arrangement of the pedicle in the abdominal wound. The author claims a revival of interest in the

operation, and that there is need for its frequent performance. The statistics are far better now than ovariectomy claimed after it had become an operation of election, and was firmly planted in public favor.

Particular attention is given by the author to tying of the broad ligaments and the use of the elastic ligature. Sewing the parietal peritoneum to that of the pedicle in the extra-peritoneal cases was also dwelt upon.

The method by ventro-fixation had given good results in the author's hands, and served to accomplish two important purposes, viz., a speedy convalescence, and avoids the disagreeable sloughing which follows the use of the wire clamp. It may also be used in some cases of short pedicle, where the wire may not easily be applied. The methods were compared and statistics furnished, showing that the extra-peritoneal method with wire and pin gave better results than either of the others. That ventro-fixation came next, and the intra-peritoneal method last, with a large mortality. A method of closing the capsule over the stump was described, which the author claimed would answer for either *dropping* it, or sewing in the wound—ventro-fixation. In the latter case the suspensory sutures are placed and the pedicle sewed in and under the lower end of the abdominal incision. Great care is required in closing the capsule over the raw surface of the stump so that separation may not occur. Owing to the peculiar contractile nature of the capsule care must be taken to leave sufficient length for approximation of peritoneal surface.

The uterine arteries are to be tied in any case when hemorrhage is likely to occur, and drainage may be required. Besides reference to methods the author described the process through which the womb passes subsequent to supra-vaginal hysterectomy.

All myomatous tissue should be removed, which can only be effected in some cases by a process of reduction of the pedicle. This is very important, as in the operation where a large amount of myoma is left, more time is required for atrophy and absorption to reduce the pedicle to its proper size. Great danger to the patient is apt to follow, where a broad base of the tumor is left in



either method of treatment, because this mass must be disposed of before the patient entirely recovers.

The author had observed a sufficient number of cases to declare that permanent fixation of the stump to the abdominal wall was the rule, where the extra-abdominal methods were used, and especially when the broad ligaments were cut away to prevent traction.

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#### SECOND DAY--AFTERNOON SESSION.

The Association was called to order by the First Vice-President, DR. J. McFADDEN GASTON, of Atlanta, Georgia.

The first thing in order was the Annual Address of the President, by DR. L. S. McMURTRY, of Louisville, Ky. Dr. McMurtry selected for his subject

#### A PLEA FOR PROGRESSIVE SURGERY.

He said within fifteen years the entire practice of surgery has been revolutionized. New methods have been introduced, and new regions invaded. Comparatively recent teachings have become obsolete in practice, and modern treatises recast. The science and art of gynecology, which a few years since was limited to a small and narrow field, has grown into a great branch of medical science and practice. Formerly divided between midwifery and surgery, as a minor branch of one or both, gynecology has become an independent and essential department of the healing art.

When Marion Sims announced through the columns of the *British Medical Journal* that he believed the proper course of treatment in every case of gunshot wound of the abdomen is to open the stomach, search for the bleeding points and secure them, and suture intestinal perforations, he was pronounced by many eminent surgeons to be a dreamer. The suggestion of Sims was most timely, and shortly afterwards Bull successfully executed the operation. For years the treatment of opium in full doses had been pursued, with death in waiting. Now there is scarcely a State in the Union that one or more patients have not been rescued

from certain death by prompt resort to operative treatment. He mentioned these circumstances to illustrate and emphasize the point, that surgery is advanced more by the aggressiveness of the surgeon than by timidity. In the face of desperate conditions of disease and injury, where there can be no safety whatever in delay and palliation, the only treatment worthy of consideration is the aggressive course which promises success. Under such conditions the most heroic surgery is conservative, and any other course is not conservative.

DR. THOMAS ADDIS EMMET, of New York, read a paper entitled  
INJURIES TO THE PELVIC FLOOR AND THE METHOD OF REPAIRING  
THE SAME.

DR. JOSEPH TABER JOHNSON, of Washington, D. C., followed with a paper on

THE GROWTH OF FIBROID TUMORS OF THE UTERUS AFTER THE  
MENOPAUSE.

He said the object of the paper was to put on record cases and opinions in opposition to this view of this important subject, and to aid in recasting our views and in modifying our practice.

He had within the past five years seen at least a dozen women with large growing and troublesome fibroid tumors of the uterus, who were over fifty years of age; some of them over sixty. These women had been assured by their physicians that if they could get along somehow until after the change of life their tumors would not only stop growing, but that they would lessen in size, and probably go away altogether; at least the troublesome and dangerous symptoms would disappear. They had been advised against any radical operation, and encouraged to believe that as they grew older they would get entirely well. In perhaps the majority of cases this might prove to be very good advice; but the point which the author wishes to make is, that as we are now better acquainted with the history and behavior of these tumors, that this is no longer safe advice to give. We cannot assure any woman that her tumor may not prove to be one of the exceptional cases, and that it may not grow more rapidly after the menopause than it

did before, or that it may not present complications equally distressing and disastrous. When from forty to fifty per cent. of women subjected to supra-vaginal hysterectomy died from the effects of the operation, this was very safe and conservative counsel to follow. The possible dangers of the tumor were not equal to the probable dangers of the operation.

The author drew the following conclusions:

1. That the "rule" stated in the text-books, that uterine fibromata cease to grow after the menopause, has many more exceptions than is generally supposed.
2. That *when* they continue to grow after the menopause, they pursue a more disastrous course than before.
3. They more frequently become cystic, calcareous or have abscesses developed in them.
4. These conditions requiring operation according to well-known rules of surgery, the patients are in a less favorable condition for recovery than before the menopause.
5. If the above conclusions are admitted to be true, it must follow that they furnish additional indications for more frequent and earlier resort to the radical operation.

In the hands of the best operators in cases where a pedicle can be secured, the mortality of supra-vaginal hysterectomy is rapidly approaching that of ovariectomy.

#### THE SURGICAL TREATMENT OF ANTERIOR DISPLACEMENTS OF THE UTERUS.

DR. C. A. L. REED, of Cincinnati, Ohio, read a paper on this subject. He said, anterior displacements of the uterus, when they exist to the pathological degree, are the opprobria of the gynecic art. It is indeed true that many wombs lean far forward without inducing symptoms, but it is likewise true that many of them that are thus malposed do entail symptoms, objective and subjective, that frequently baffle our resources. It is a misfortune, too, that in many of all the displacements to which the womb is liable, those in which the organ deviates anteriorly to the normal axis are vastly the more prevalent. Thus in an aggregate of four hundred and ninety-four cases by Nonat, Meadows, Scanzoni, Val-

leix and Hewitt, quoted by Thomas and Munde, there were two hundred and ninety-four ante-flexions, and one hundred and eighty retro-flexions; while Munde himself reports two hundred and ninety-four ante-flexions, thirty-three retro-flexions and ten latero-flexions in a total of three hundred and thirty-seven cases. As the latter authority is disposed to look upon ante-flexions in their minor stages as a physiological (even congenital) condition, it is legitimate to infer that his statistics are based upon observations of displacements in the pathological degree. The conclusion is forced upon us, then, that of all the displacements of the uterus, those of the anterior variety are the more frequent; while the records of practice will force us, likewise, to the conclusion that of all the womb displacements those of the anterior variety are less amenable to treatment than are any of the others.

In the treatment the term *surgical* is employed in contradistinction to any method of treatment by pessaries, tamponnade, or electricity. It may be premised that all surgical methods devised for the relief of these conditions should be directed, first, to the removal, when practicable, of the causes of the diseased conditions proper, and, finally, to the readjustment of the diseased organs to the normal physical forces of the pelvis.

In conclusion the author desired the Association to consider:

1. The etiological relationship of contracture of the utero-sacral ligaments to ante-flexion.
2. The possibility of overcoming this condition by such conservative measures as rest, pelvic depletion and appropriate manipulations.
3. The feasibility of removing the obstructive dysmenorrhœa and the sterility usually incident to these cases by the plastic operation which he had described.
4. The inexpediency of forcible dilatation for the relief of these cases and its inability to effect a permanent cure.

#### THE PART THE SHOULDERS PLAY IN PRODUCING LACERATION OF THE PERINEUM, WITH SUGGESTIONS FOR ITS PREVENTION.

This was the title of a paper read by Dr. W. D. Haggard, of Nashville, Tennessee, in which he made the following suggestions:

1. The patient should occupy the left lateral decubitus, at least during the second stage of labor.
2. Overcome rigidity of the vulvar outlet by the judicious use of chloroform.
3. The presenting part of the child should be supported and not the perineum during the passage of the head and shoulders.
4. Support the head by pressing it well up under the symphysis pubis by placing the right thumb in the rectum and fingers of right hand expanded over the occiput.
5. To retard the exit of the shoulders, pressure should be applied to the trunk and shoulder by placing the index and middle fingers of the left hand in the rectum with the thumb in the vagina to restrain its exit.
6. Support the head and neck by pressure well over the symphysis pubis.

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THIRD DAY—MORNING SESSION, NOVEMBER 12.

The Association was called to order by the President at 10 A. M.

DR. JAMES A. GOGGANS, of Alexander City, Ala., read a paper entitled

ABDOMINAL SECTION IN A CASE OF CYST OF THE MESENTERY.\*

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THINNESS OF UTERINE WALLS SIMULATING EXTRA-UTERINE PREGNANCY WITH REPORT OF TWO CASES,

was the title of a paper by DR. GEO. J. ENGELMANN, of St. Louis, Missouri.

The author said there are many difficulties in the way of a positive diagnosis of early pregnancy, even in cases surrounded by conditions less unusual, but they assume alarming proportions when aggravated by the curious complications which may arise in individual cases, above all when conditions are simulated in which delay is dangerous and operative interference seems called for; when a decision is urgently demanded, a decision upon which a life, and perhaps two, may depend. Whilst the auditor may criticize at his leisure and readily differentiate the conditions depicted, it is only he who is to pronounce and to act who can realize the difficulties of this entangling and so knotty problem.

\*To be published in this journal.

CASE I.—Patient, 32 years of age, had borne three children in the six and a half years of her married life, the youngest twenty months ago, which she was still nursing, and the menstrual flow has not as yet reappeared since the birth of this child. The patient came to his clinic for relief from a variety of discomforts from which she had been suffering more or less for the past three months. She complains of sick headache, vomiting spells, fulness of the stomach, belching after meals and an intermittent swelling of the abdomen; a pain in the groin, appearing before such swelling and a small tumor above the right groin, which she had first noticed three weeks ago and as she stated, “then suddenly made its appearance.” An examination revealed large varicose veins over the lower limbs; a solid, round, movable tumor above symphysis and right groin; the cervix low and large; the uterine body thickened, lying low in the pelvis, with a certain mobility independent of the superimposed tumor; an applicator entering three and a half inches slightly *ante*. Notwithstanding the wine color of the pronounced cystocele and the cervix, pregnancy seemed out of the question, and the tumor was diagnosed as most probably a dermoid of the right ovary, hardly one connected with the uterine wall. In the course of an examination two weeks later, a very different condition of affairs was revealed. The tumor had disappeared, and a fœtus was found in the utero-vesical space, freely movable, apparently floating about, the small parts being distinctly felt as if underneath a wet towel both through the vagina and abdominal walls. So distinct did the small parts appear to the examining finger, that it seemed impossible to realize that even as much as a thickness of the vaginal tissues should intervene, and the abdominal walls must certainly have been very much attenuated to disclose the foetal parts with such distinctness. Probe showed the uterine cavity free six and a half inches in length, still slightly *ante*, but never curving forward in the direction of the previous tumor.

The treatment for the supposed subinvolution was discontinued, the patient warned to keep quiet and to notify Dr. Engelmann upon the occurrence of any abnormal symptoms. He believed the case to be one of ectopic gestation, either within the broad liga-

mentor in the abdominal cavity after tubal rupture marked by the sudden appearance of the tumor five weeks ago, yet he was not sufficiently positive to warrant the immediate resort to the knife, and well that he did not do so, as persistent treatment and repeated examinations resulted in labor pains and the delivery of a five months' fetus in the most correct and natural manner.

DR. ROBERT T. MORRIS, of New York, contributed a paper on  
THE REMOVAL OF NECROTIC AND CARIOUS BONE WITH HYDRO-  
CHLORIC ACID AND PEPSIN.

The author said sometimes it is desirable to remove dead bone without subjecting a weak patient to a dangerous or deforming operation. Attempts have been made with some success at clearing out this bone by a process of decalcification, but there are two chief reasons why failures have resulted as a rule. In the first place, it was discovered that superficial layers of dead bone were decalcified easily enough, but the acids did not reach deeply through the mass, especially if portions were infiltrated with caseous or fatty debris. In the second place, cellulitis was pretty apt to develop during the course of treatment.

After much experimentation he had finally adopted the method of work which seemed to be complete. An opening is made through soft parts by the most direct route to the seat of dead bone, and if sinuses are present they are all led into the one large sinus, if possible. The large direct sinus is kept open with antiseptic gauze, and the wound allowed to remain quiet until granulations have formed. Granulation tissue contains no lymphatics and absorption of septic material through it is so slow that we have very good protection against cellulitis. The next step consists in injecting into the sinus a two or three per cent. solution of hydrochloric acid in distilled water. If the patient is confined to bed, the injections can be made at intervals of two hours during the day; but if it is best to keep the patient up and about, the acid solution is thrown into the sinus only at bed-time. In either case the patient is to assume a position favorable for the retention of the fluid. Decalcification of exposed layers of dead bone takes place quickly, and then comes the necessity for another

and very important step in the process. At intervals of about two days an acidulated pepsin solution is thrown into the sinus (he uses distilled water,  $\text{ziv}$ ; hydrochloric acid, m.  $\text{xlvi}$ ; Fairchild's pepsin,  $\text{zss}$ ), and this will digest out decalcified bone and caseous and fatty debris in about two hours, leaving clean dead bone exposed for a repetition of the procedure. The treatment is continued until the sinus closes from the bottom, showing that the dead bone is all out.

Even in distinctly tuberculous cases the sinuses will close if apparatus for immobilizing diseased parts and tonic constitutional treatment are employed, as they should be, in conjunction with our efforts at removing the dead bone. If suppuration is free in any cavity in which we are at work, it is well to make a continual practice of washing out the cavity with peroxide of hydrogen before each injection.

It is a popular impression in the profession that living bone is not attacked by dilute mineral acids, but as it makes a good deal of difference whether the impression is correct or not, he experimented as follows: A portion of the keratinoid layer was removed from the carapace of a turtle (*nanemys guttatus*), and the animal was then placed tail downward in a glass of five per cent. hydrochloric acid solution. In the glass he placed also a segment snipped from the plastron of the turtle, and a transverse segment from an old dry humerus of a man. The piece of humerus was completely decalcified in six hours; the segment from the plastron was soft in about twenty hours and the carapace of living bone was decalcified at the exposed part in thirty hours. He was then curious to know what effect the acid had had upon the blood vessels of the decalcified bone, and Dr. Smith of the laboratory of the Post-Graduate Medical School made for him several sections of the carapace, which included both decalcified and healthy bone. Investigation showed that all of the blood vessels were destroyed wherever the bone was softened, and the action of the acid had extended farther up along the larger blood vessels than elsewhere.

The difference in time between decalcification of the dead



bone, six hours, and of living bone, thirty hours, is significant; a five per cent. solution of the hydrochloric acid having been used. If we use a two or three per cent. solution of hydrochloric acid, a wall of lymph and of granulation tissue is thrown out upon the surface of the living bone for protection, and only dead bone is attacked. This at least has been his observation in several cases in which the results of treatment could be easily watched.

DR. LANDON CARTER GRAY, of New York, in a paper entitled

#### THE PRESENT STATUS OF CEREBRAL SURGERY,

touched upon the modern aspect of intra-cranial surgery. The speaker first passed in review our present knowledge of localization of functions of the brain, stating that we are well acquainted with the functions of the motor area, of the third frontal convolution, the frontal lobe, the Island of Reil, the two upper temporal convolutions, the cuneus, certain portions of the basal ganglia, the base of the brain and the cerebellum, and that we knew nothing, or had still under discussion the question of the localization of the centers for the sensations of touch, pain, muscular sense, temperature sense, most of the parietal lobe, and most of the temporo-sphenoidal lobe with the exception of the olfactory lobe. He stated that operations for fracture of the skull with or without hemorrhage, for abscess, and for tumors that were removable and localizable were usually successful; those for so-called idiopathic epilepsy were utterly valueless, as were also those for epilepsy supposed to be due to genital or ovarian irritations, whilst those done for epilepsy due to removable and localizable lesions of the intra-cranial contents were usually successful so far as the lesion was concerned, although it was a grave question as to whether the epileptic habit was ever cured. The latest operation for idiocy supposed to be due to premature ossification of the fontanelles was still under discussion and consideration, the cases being too few and too recent to permit of any conclusion; whilst the operations for hydrocephalus and for epilepsy due to such early infantile and foetal lesions as parencephalus, hemorrhage and meningitis were indefensible. He further impressed upon surgeons the great diffi-

culty that there often was in finding a sub-cortical lesion of the centrum ovale that was deep seated or small, and the fact should be borne in mind that there might be no decussation of the motor fibres from the hemispheres, so that a lesion would be found upon the same side as the paralysis.

SOME COMPLICATIONS OF PSOAS ABSCESS.

This was the title of a paper read by Dr. J. McF. Gaston, of Atlanta, Georgia.

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THIRD DAY—AFTERNOON SESSION.

DR. PAUL B. BARRINGER, of Richmond, Va., read a paper on  
VENOMOUS SERPENTS OF THE UNITED STATES AND THE TREAT-  
MENT OF WOUNDS INFLICTED BY THEM.

DR. CHRISTOPHER TOMPKINS, of Richmond, Va., followed  
with a paper entitled

A CASE OF INDUCED ABORTION FOR RELIEF OF NAUSEA AND  
VOMITING, WITH REMARKS.

On August 1, 1885, he was called to see Mrs. J., aged twenty-four, and as nearly as could be ascertained, three and a half months pregnant with her first child. Patient was born in the mountainous part of Virginia; she had led an active outdoor life and grew up to be a woman of good height and of round full figure. January 14, 1884, she married.

While in the city of New Orleans, in stepping from the platform of a car, she sprained her ankle. This, although treated immediately by a physician of that place and subsequently in this city, caused her great suffering. Finally, refusing to yield to the usual treatment, the part was put in a plaster cast; she went about on crutches, and after many months recovered. In the meantime she became pregnant and from the first was attacked with nausea and vomiting. Mild in the beginning, it gradually increased in gravity, till she sent for him on the 1st of August, 1885.

Her husband stated that she had had fever for two weeks. He found her in bed and learned that she had been there for days; her figure not robust, and her face thin and attenuated. What little she had eaten in the past ten days or two weeks had been apparently rejected, her temperature one degree above the normal; tongue foul; sordes on the teeth, and the breath of a sour and bilious odor. The pulse was fairly good, considering her condition. Even the mention of food was distressing to her, and the sound of the dinner bell, though far off from her, caused such distress that its ringing was discontinued by the family. The bowels had throughout her pregnancy been constipated, only moving once in two or three days. Although continually retching, very little or no blood had been seen in the material vomited, except on two occasions, and then not a great deal, and such as there was was of a florid, scarlet color. No medicine has been given and no treatment taken, except the occasional use of lime water, which she said "did no good."

The patient did not improve up to August the 7th, when Dr. Tompkins, thinking the case one of the greatest gravity, and that the question of abortion could no longer be deferred, invited Drs. J. B. McCaw and Aaron Jeffrey to meet him in the afternoon in consultation. All agreed that abortion must be produced, in order to give the patient a last chance for her life, which was done.

*Remarks.*—The case is reported principally because it was an unsuccessful one, and because he wished to disabuse the minds of those who are not experienced in such operations of the notion, commonly believed and often expressed, that the induction of abortion for the nausea and vomiting of pregnancy is in skillful hands an undertaking devoid of danger and necessarily attended by success. In this case he is of the opinion that death was the result of the protracted debility and an enfeebled constitution, due to her long confinement and suffering; first, from the injury to her ankle, from which she had not recovered when she became pregnant and was attacked by nausea and vomiting, this last continuing till her death. Under such circumstances the outlook was indeed very unfavorable, for to the shock of

operation and depression incident to the use of chloroform, there was added fever and protracted prostration, both from injury to the ankle and from want of nutrition, the result of the long existing nausea and vomiting. He had before and since operated on women for the nausea and vomiting of pregnancy, and with success, whose apparent condition was much worse than that described in the above case, but without the history of a previous injury or disease.

The prognosis, always unfavorable, ought, when the case is so complicated, to be of the most guarded kind. The practitioner should not, however, hold his hands on this account, for the operation affords the poor sufferer the only opportunity of relief. The author uses metal dilators instead of tents, and completes the operation at one sitting. He is likewise convinced that the least possible chloroform used the better the result.

The following officers were elected:

*President*—Dr. J. McFadden Gaston, Atlanta, Ga.

*First Vice-President*—Dr. Cornelius Kollock, Cheraw, S. C.

*Second Vice-President*—Dr. Geo. Ben Johnston, Richmond, Va.

*Secretary*—Dr. W. E. B. Davis, Birmingham, Ala.

*Place of Next Meeting*—Louisville, Ky., second Tuesday in November, 1892.

*Chairman of Committee of Arrangements*—Dr. L. S. McMurry, Louisville, Ky.

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**CARBUNCLES.**—Dr. A. E. Spohn, writing in the *Medical and Surgical Reporter*, states that he has had excellent results in the treatment of carbuncle by the external use of a ten per cent. solution of chloral hydrate in glycerine and water, applied constantly by means of absorbent cotton, combined with the internal administration of sulphide of calcium. He was led to use the chloral externally to relieve the pain, and was surprised to find that it also had curative effect.—*Exchange*.

## GYNECOLOGICAL AND OBSTETRICAL SOCIETY OF BALTIMORE.

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NOVEMBER MEETING.

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The President, DR. WILLIAM E. MOSELY, in the chair.

DR. JOHN MORRIS gave an address entitled

### A PARTING WORD UPON OBSTETRICS.

I began the practice of obstetrics forty-six years ago, and for the first four years kept a record of my cases. The first year I attended thirty-five cases. I was associated with Dr. Hintze, who, at that time, had a very extensive general practice, and who was very often called to assist midwives in their troublesome cases. I kept a careful record of my first 200 cases, but after that I abandoned the record, a fact which I have since very much regretted. My first case was a very unfortunate one. I attended the patient in my student days. This woman was in the country, and was in labor three days. At the end of that time I sent for Dr. Hintze, who delivered her with the crochet. On account of the long impaction of the head, the whole of the anterior wall of the vagina sloughed away. The woman is still living, but so much tissue was destroyed that it was quite impossible to close up the opening, and all these years the urine has been passing from her as rapidly as secreted.

My second case was a black woman who had a prolonged labor. I had never seen the forceps used, but tried to put them on and failed. After a while the child was born without any artificial assistance.

One of my great difficulties in my first cases was to find the cervix. I had never had any practical instruction in obstetrics and did not know that in the first stage before much dilatation that the os is usually found far back against the sacrum. Among other things that I think I have learned is how to shorten labor. One of the best means of accomplishing this is by external

pressure. I learned that from my master, Dr. Hintze. Another was to pass the cervix around the occiput; and I found that these two shortened labor very considerably. I think I acquired the art of preserving the perineum. I believed in keeping the head under control and not allowing it to be delivered too rapidly. In Ireland I learned how to preserve the perineum when using forceps. The secret is simply to change the axis of traction as the head comes to the perineum first upwards, perpendicular to the bed, and then carrying the handles far over on to the abdomen of the mother.

I have found that midwifery is underrated in the profession; but I am convinced that in no branch is there greater opportunity to display skill and judgment. This branch is esteemed much more highly now than formerly.

Formerly in conditions of rigid cervix it was the practice to bleed. I have done it many times, but it would not be tolerated now. I am convinced that hot water injections will assist in relaxation. I have no faith in belladonna. I have been fortunate in not seeing any cases of hemorrhage. I believe external pressure used during labor will prevent post partum hemorrhage. For the first ten years I used ergot in nearly every case during the second stage, but have not used it now for fifteen years. In cases of delayed labor I now prefer the forceps to ergot.

The crochet has gone out of use, but formerly it was used frequently. Often the woman was injured, and not unfrequently the doctor's fingers suffered. Dr. Hintze had a glove to protect his fingers. We had at that time no chloroform, and often in transverse positions the woman would die undelivered because it was not possible to turn and deliver. I have not habitually used anesthetics, except in forceps cases. I have thought that they prolonged the labor, but I always use chloroform when any force is to be resorted to.

I have never used the binder, because I could never see the philosophy of it. It will not stay in position and it is absurd to think it controls hemorrhage. The only good that I could ever see that it accomplished was to please the woman.

**WHEN TO USE FORCEPS.**—Always use forceps when labor is delayed in the second stage. The old forceps were a much weaker instrument than the ones constructed on the Tarnier principle. I think the Tarnier forceps the greatest advance in obstetrics in my time.

In placenta previa and in abortion we formerly used a tampon made of a handkerchief, rags, cotton or anything that could be had. These tampons were dirty and dangerous. Later I have used only the colpeuryntur. It assists to dilate the os as well as being the most efficient tampon. It is clean and harmless.

Opium is the best thing to relieve pain in labor. It does not arrest the labor. When the os is dilated it increases the contractions.

DR. F. E. CHATARD exhibited to the society the obstetrical instruments used by his grandfather (1810-1840), and also those used by his father (1835-1875). He stated that he had used external pressure with apparent good effect.

DR. WILMER BRINTON stated that external pressure was used by primitive people. He thought that in rigid os he had gotten good results from the administration of chloral in fifteen grain doses every fifteen minutes until three doses were given, as recommended by Playfair. But the number of cases in which he had given chloral was small.

DR. G. LANE TANEYHILL had used chloral per anus with great satisfaction in three cases. In less than an hour the os had been considerably dilated and delivery was effected in each case within three hours, other remedies having failed. He had learned this treatment from our learned fellow member, Dr. Williams. He uses thirty grains of chloral in milk.

DR. P. C. WILLIAMS thought it was very important to consider agents to relax the parts. Chloral in forty to sixty grain doses per anus had given good results, but sometimes it, as well as chloroform, fails to completely relax the cervix. In his earlier experience he had encountered many cases of post partum hemorrhage, but since he had made use of a practice that is condemned by most obstetricians, that of giving ergot before chloroform, he had not had a single case of hemorrhage. He

had seen no harm result from the practice, but thought he had in this way shortened the labor. The objections to morphine to relieve pain is that it nauseates badly afterwards. Chloral must be pushed to get good effects. The objection to it is that sometimes it leaves the patient more or less delirious, and may seriously depress the heart if given too frequently.

DR. WILLIAM S. GARDNER had used chloral in fifteen grain doses, repeated every fifteen minutes, in a series of cases, and found that while the patients had very little relief from pain, that a large percentage of them would be made sick at the stomach and the discomfort caused by the disagreeable taste of the drug and by the vomiting following its use more than counterbalanced the little good it did, and its use in this way was abandoned. He gives it frequently for the relief of false labor pains. A dose of thirty grains will almost invariably relieve the pains and put the woman to sleep.

DR. WM. P. CHUNN had used chloral a number of times but could get no positive evidence of its value, but it does not seem to obtund the pain. If opium will do this it might be advisable to use it.

DR. L. E. NEALE was surprised that a discussion as to the value of chloral should be brought up. He thought that the time for discussion of that subject had passed. Whether it would act more efficiently by the rectum or by the stomach he did not know, but he thought sixty grains too large a dose and would be afraid to use that much as an ordinary dose by the mouth.

The remarks were entirely too general to admit of special discussion.

WILLIAM S. GARDNER, M. D.,

712 N. Howard St.

Secretary.

EARACHE.—The following is recommended for the relief of earache: Chloroform, 1 part; olive oil, 8 parts; put from twenty to thirty drops of this solution in the auditory canal, closing the ear with cotton. When the earache is due to a furuncle in the external auditory meatus, an application of a solution of 1 part of menthol in 20 parts of oil of sweet almonds often brings almost instantaneous relief.—*Medical Record*.



## Correspondence.

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### OUR NEW YORK LETTER.

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NEW YORK, November 16, 1891.

#### ETIOLOGY OF CHANCROID.

At the last meeting of the Academy Section on genito-urinary diseases, the Chairman, Dr. R. W. Taylor, read a paper on the etiology of chancroid. He stated that his own researches, in connection with those of Dr. Bumstead, had overturned the dualistic doctrine of the origin of venereal sores. Chancroid was not caused by any specific virus, and Fournier was wrong in claiming that the presence of such a sore indicated positively that there had been contact with another chancroid. It could be produced by contact with any pus rich in pyogenic microbes, and bore the same relation to a mucous membrane that impetigo and ecthyma did to the skin. He had himself seen chancroid result in the male when the female organs were free from similar lesion. In one such instance he had discovered an ulcerating fissure of the cervix, which was intensely inflamed. He had also observed sores in all respects similar to chancroid, which had originated without sexual intercourse at all. Herpetic lesions might degenerate into ulcers. He had seen a case in which such ulcers had recurred at intervals for years; and although they had always been called chancroids by physicians, the patient was sure that they often appeared irrespective of intercourse. In another instance buboes resulted and auto-infection of the thighs. from ulcers due to herpes, at a time when the patient had not had intercourse for three months. Syphilitic subjects were more prone to chancroid, as their tissues were more susceptible.

Dr. P. A. Morrow thought that the cases in which chancroid

resulted from infection with simple pus were exceptional; in the immense majority of cases chancroid was produced by chancroid or chancroidal bubo. Herpetic lesions might ulcerate, and the sores might resemble chancroid; the breaking down of tubercular lesions in syphilitic subjects might also cause similar sores, but the exceptions to the rule formulated by Fournier were so few as to be disregarded. Certain conditions of uncleanness and excess tended to ~~foster~~ the development of chancroid, but ~~were not~~ the actual causes.

Dr. G. E. Brewer would abolish the term chancroid altogether, as misleading. Chancres and herpes were produced by certain specific causes. It was not so with chancroid, which were simply septic sores, and should be so referred to.

Dr. Taylor said, in closing, that it had been proved experimentally that lesions similar to chancroid could be produced by inoculations with pus from impetigo and ecthyma. He thought, then, that these sores should be regarded as merely examples of wound infection.

#### NITRATE OF SILVER IN GONORRHOEA.

At the same meeting Dr. Ramon Guiteras gave an account of his experience in treating gonorrhœa with injections of solutions of nitrate of silver of increasing strength. He gave a short history of the use of this remedy in the treatment of gonorrhœa, beginning fifteen or twenty years ago, when weak solutions of one-fifteenth of a grain to the ounce were used. Later the abortive treatment by the injection of strong solutions was practiced by some. Bumstead had used a drachm of a solution containing sixty grains to the ounce. This treatment was not successful as an abortive measure, however, and sometimes caused peri-urethritis. Nitrate of silver was not much used at present except in long continued cases when the deep urethra and bladder was effected. In these cases the deep injection of a few drops of a strong solution by means of a Keyes' or other suitable syringe was extremely useful. He had tried the remedy in acute cases and had had considerable success. His method consisted in the daily injection of a solution containing at first one

grain to the ounce and increasing the strength up to fifteen grains to the ounce in some cases. In the majority, a solution containing eight or ten grains to the ounce was sufficient. Three to five injections produced a cure in some instances, and as the cases had not returned for further treatment, he believed the cure to be permanent. The only other treatment prescribed was the use of a solution of borax—a drachm to four ounces—as an injection to be used by the patient. His observations had led him to conclude that the use of nitrate of silver in gonorrhœa was not dangerous, but that the point of toleration was reached in most cases in a solution of eight grains to the ounce. A dry, irritable, congested condition of the mucous membrane remained afterwards, which required a mild astringent.

Dr. Brewer said that his experience in the treatment of gonorrhœa had produced three stages of feeling in him. The first had been a stage of dissatisfaction, when he had used internal medication; the next was one of enthusiasm, when he had treated a large number of cases with injections of solution of bichloride of mercury (see July number). He had now reached a stage of despair. He thought the nitrate of silver well worth trying, and he had already seen it do good in some cases.

Dr. Morrow's experience with nitrate of silver had not been so satisfactory as that of Dr. Guiteras. He had not used it in exactly the same way, however, and would adopt the plan suggested, at least tentatively.

Dr. Agramonte said that the success of nitrate of silver in the treatment of gonorrhœal ophthalmia was a strong argument for its adoption as a remedy for gonorrhœal urethritis. It had been proved experimentally that a solution of five grains to the ounce would destroy the gonococci instantly, and he thought there was no reason for employing solution of any greater strength.

#### THE KEELEY "CURE" FOR DRUNKENNESS.

The Keeley "cure" for drunkenness and the opium habit has come among us. A branch establishment has been opened at White Plains, a few miles away, and there hundreds of unfor-

tunates are flocking daily. Dr. Keeley, the discoverer of the "cure," lives in Dwight, Ill., and has advertised for several years in a small pamphlet, setting forth his long experience, and the wonderful efficacy of the bichloride of gold, prepared and used properly by him only. It is only recently, however, that he has attracted general attention. Several "cured" drunkards, some of them quite prominent people, have announced the fact of their recovery from the disease of drunkenness, as it is termed by Dr. Keeley in the public press, and the result is that a large increase in Dr. Keeley's income has occurred. It is stated that as many as six hundred patients have been observed in line before his office waiting to receive a hypodermic injection. Four injections are given daily, medicine being taken by the stomach every two hours during the interval. No restrictions are placed on the patient while under treatment, as the remedy is said to remove all desire for stimulants. It is claimed that 95 per cent. are cured.

The newspapers have devoted considerable attention to the propriety of concealing the nature of the remedy, some taking one view and some another. It is stated that Dr. Keeley keeps his secret because of Koch's experience, and that if the medical fraternity will acknowledge the justice of his claims beforehand he will publish every fact connected with it. It must be said, however, that the prevailing opinion expressed by the newspapers is that the actuating motive is the desire for gain rather than the good of humanity; a silent tribute thus being paid to the time-honored rule of the profession regarding inventions and discoveries.

The remedy is announced by Dr. Keeley to be a double chloride of gold, but its exact nature and the manner of using it have not been explained, and all our knowledge of its virtues is derived from Dr. Keeley's claims and the statements of those who claim to have been cured. Among the more prominent of these was Mr. C. F. Mines, known in literature as "Felix Old-boy," who gave a forcible account of his experience in the *North American Review*. He expressed his satisfaction of a cure, which had then lasted for two years. His recent death from the effects

of a prolonged spree can hardly be regarded as favorable to Dr. Keeley's claims. I have also heard of another case who was discharged "cured," and four days later started out as before to drink himself dead drunk.

As the remedy has not yet been scientifically investigated, a judgment on its merits cannot be pronounced. It is certain, however, that the history of medicine does not warrant us in expecting great benefits to humanity to accrue from remedies first announced on tinted advertisements sent out to attract patients to the alleged discoverer.

The remarks of Oliver Wendell Holmes at the opening of the Academy about a year ago recur to me now with renewed significance. "Nowhere is such a defence more needed than in the science and arts which deal with the health of the community. The public is so ready, so eager to be deceived, and the traders in deception are so willing, so hungry to deceive those who will listen to them, that it needs a solid wall of resistance, a close phalanx of men of recognized sense, knowledge and character to stand against them."

WM. L. RUSSELL.

151 East Fiftieth St.

TREATMENT OF HEPATIC COLIC BY OLIVE OIL.—Dr. Willem presents in *Bulletin Generale de Therapeutique* an account of nineteen cases of hepatic colic occurring in the practice of others, which have been successfully treated by the use of olive oil, and nine cases occurring in his own practice treated by the same agent. In all these cases there was a cessation of pain soon after administering the oil. The usual quantity given was six ounces of the pure oil, repeating the dose until all pain had disappeared. Nausea and vomiting promptly ceased, and the icterus gave way before the use of the remedy. The fever sometimes existed a longer time. If a second attack followed, another dose of the oil was given with the same happy results. The oil sometimes gave relief to pain when light foods and opiates could not be tolerated by the stomach. Many months sometimes elapsed before the attacks returned, if at all. The author does not believe it possible to relieve the sufferings of hepatic colic by suggestion alone, but maintains that something more is necessary to relieve these horrible pains. Olive oil seems to act as a solvent of the biliary concretions, rendering them more difficult of detection after they have been passed.—*Medical Age*.

## A CARD.

ATLANTA, GA., Nov. 22, 1891.

*Editors Atlanta Medical and Surgical Journal :*

Our acknowledgments and thanks are due the gentleman who complimented us with an editorial allusion in the last number of the *Southern Medical Record*. The insinuation is, that we have accepted a pittance at the hands of the East Tennessee, Virginia and Georgia Railway, and our competency is questioned, if not assailed.

With becoming modesty, we hold that we are as honorable and as ethical in our methods as the writer of that criticism.

The blame, the fault, is not with the physician who accepts the place, but with the profession which deals in double weights and measures, smiles on some of its members and frowns on others.

Why does not the medical profession, through its national, State and local organizations, condemn and anathematize both the offer and the acceptance ?

Why does not the Georgia Medical Association repudiate its former president, vice-president and censor who wrote the tariff for the Georgia Railroad, a tariff similar to and almost identical with that of the East Tennessee, Virginia and Georgia Railroad ?

Nine-tenths of the medical profession of Atlanta pity Olmsted for refusing Ford's bill of fare and approve of Cooper accepting it! Again, nine-tenths of the medical profession of Atlanta pity Olmsted for rejecting Ross' proffered fee bill and approve of Nicolson accepting it! Consistency, thou art a jewel!

We of the East Tennessee, Virginia and Georgia Railroad are held in ridicule and almost contempt, for having subscribed to Drake's fee bill.

To use a French expression, our Code of Ethics "n'a ni cul ni tete." We would like to find its head, and know something of tail. We would like to know why it is *censorially* ethical to propose and ridiculously little to accept ? We would like to know why the Georgia Railroad and the Richmond and Danville

Railroad are spared the criticism of that editorial in the *South-ern Medical Record*?

Throw off your mask and confirm our suspicions! We suspect that Nemesis had more to do with the inspiration of that editorial, than a wounded sense of the violation of ethical rules and methods.

With respect to the insinuation of "poor pay, poor surgeons," we have every reason to flatter ourselves that we are as competent as the denouncer.

E. VAN GOIDTSNOVEN, M. D.

**A MARTYR FOR SUBSTITUTION.**—In a recent issue of the *National Advertiser* the following item was copied from the *Bulletin of Pharmacy*:

M. Herrouet, a pharmacist of Mans, France, has retired to the seclusion of one of the French prisons for three months, the better to consider the evils of substitution. A physician had prescribed a hypodermatic injection of apomorphine, for a child three months old. The prescription was presented to M. Herrouet for dispensing, who, having no apomorphine, substituted morphine hydrochlorate, under the impression, as he admits, that the result would be the same. The physician, ignorant of the change, administered the injection; the child immediately fell into a comatose condition and died of poisoning shortly afterwards. M. Herrouet was prosecuted for homicide by imprudence, and the court decided that three months' solitary and careful thought would probably convince him that it is always best to dispense a prescription as written or not dispense it at all. We would just remark *sotto voce* that substitution on physicians' prescriptions is not confined to France.

## Editorial.

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DR. L. P. KENNEDY.

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In our last issue we announced that Dr. Kennedy seemed on the road to recovery.

It pains us to have to announce that the doctor has since developed less favorable symptoms and his condition is now critical.

Dr. Kennedy has been one of the proprietors and editors of THE JOURNAL for the past two years, and his associates have had ample opportunity of proving his character as an honest, upright, sincere Christian gentleman.

His numerous friends, and his associates upon THE JOURNAL, hope to soon see him well again, and once more in the position which he so well filled.

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### A TEXT FROM A SERMON.

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On Sunday, December 6, 1891, that eminent and famous Baptist divine, the Rev. J. B. Hawthorne, D. D., preached an able sermon upon the subject of "*Lies and Liars.*" We take as our text the following paragraph, published in an abstract of the sermon in the *Atlanta Constitution* of the following day :

*"In this category I would place the blood purifier and the liverpad man, who have discovered the greatest remedies of the age."*

"This category" is the category of liars. Dr. Hawthorne always preaches on timely subjects and is noted for the fearless-



ness with which he handles them, no matter whose feelings may be hurt. This fearlessness is the more commendable when we remember that it is not conducive to the preacher's personal popularity. The "blood purifier man" keeps pace with medical progress—as may be seen from his advertisements. If disease is due to "*a humor in the blood*," his medicine is the "purifier" which cleanses the system of the offending substance. If the disease is due to "*germs*," he cries, presto! change, and straightway the advertisement tells the afflicted people that the medicine kills these *germs*, or "*drives them out through the pores*"

Now we get to the point desired, and are able to relieve the doctor of our first suspicion that his condemnation of "blood purifier and liver-pad men" did not cover the ground, and of the suspicion that "germ-killer" men were not to be classified with the "blood-purifier" liars, for they are now all in the same "category."

Two patent medicines will be remembered as having been extensively advertised a year ago, and one of these was editorially commented upon by one of the city papers—this editorial being commendatory, and, being in that part of the paper where the reader seeks editorial brain pabulum, was duly absorbed and digested by both laity and doctors.

These "germ-killers" were known respectively as "Microbe Killer" and "*Royal Germateur*." The former was a Texas product, and we will dismiss it to the consideration of its fellow citizens. The latter is (to the writer) of uncertain origin, but the ownership, alas, of some of the stock of this company has been said to be vested in certain *Georgia preachers*, and not any of your "cross-roads," "one-horse" or local preachers, but preachers whose signature to the certificates of the worth of "*Germateur*" would exert a national influence. Now, let us not be understood as saying that a preacher who privately owned

*stock* in a patent medicine would try to increase *its* sales, and *his* dividends, by allowing his name to appear at the bottom (or top, in large letters) of a certificate as to the "medicine's" curative properties. That would not be in good taste. The bad blood-purifier (or germ-expeller, not germ-killer) man might do such a thing.

Now we come back to the puzzling question of how much "blood-purifier man" covers in the sermon? Is a "blood-purifier man" supposed to be a "higger," or the only, liar; or, as the "blood-purifier man" *runs the germs out*, does that qualify him as a liar, or must we let the blood-purifier, the germ-expeller and the germ-killer man come under the condemnation of our text?

We are constrained to believe that we must, and to commend our eminent preacher for the candor and fearlessness of his characterization, and for his daring to do and speak "right" even if in so doing his "brother" ministers fall under the ban. We hope the words of the sermon may influence said ministers to sell their stock, or give it away, *if they still own it*, and thus stand aside from the "category of liars," and array themselves, *purged and forgiven of lies*, on the side of *decency, consistency and truth*.

"Germateur" is said to be in a bad way; large advertisements no longer appear, and the *expose* of its contents has doubtless rendered it no longer a profitable investment. But even if it is, what influence can that exert upon the *preachers* who stand condemned by the burning words of our text?

#### "LIES AND LIARS."

"*In this category I would place the blood-purifier and the liverpad man, who have discovered the greatest remedies of the age.*"—Rev. J. B. Hawthorne, Sunday, Dec. 6, 1891; *Constitution* report Monday, Dec. 7, 1891.

### "IS DRUNKENNESS CURABLE?"

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The public of late has been furnished with an abundance of literature touching the curability and non-curability of drunkenness. Obviously it is a matter of universal sociological importance. In the *North American Review*, for September, the subject is ably discussed by such eminent authorities as Dr. W. A. Hammond, Dr. T. N. Crothers, Dr. Cyrus Edson and Dr. E. N. Carpenter, and the views of these gentlemen, we believe, represent very accurately the views of the profession generally. As to the medical treatment of this diseased condition a certain method is being practiced considerably throughout this country, well known as the "Keeley Cure," which originated at Dwight, Illinois. Numerous "Keeley Institutes," modeled after the original, have been established in different cities.

The therapeutic agent employed is the bichloride of gold, hypodermically injected, four times daily for four or five weeks. The use of whisky during the course of treatment is not interdicted. This therapeutics is said by one of the regenerated to create a positive loathing for liquor. Dr. Keeley guarantees a cure of 95 per cent. of his cases, but seems willing to allow that 1 per cent. irretrievably fall from grace.

So much for the method and what is claimed for it.

Now we may say, without fear of successful refutation from the converts to the Keeley system, that there is no specific for drunkenness. It is a habit which may be so much indulged as to become almost one's normal state of existence. Like all other habits, it is not amenable to drug treatment. Drunkenness means a moral perversion, a weakening or complete loss of will power, a mental degeneration. To the poor victims who become slaves to the habit the craving for drink is too often absolutely

irresistible. Under these circumstances, there is no drug in the pharmacopœia, or out of it, that can remove this insane thirst for alcohol. A patient and careful search for some such drug has been made since this ancient curse first afflicted humanity, and among the agents employed have been the tincture of capsicum, gentian, nitrate of strychnia, the bromides, etc. These, and others, have been tried and found wanting.

The newest remedy, so-called, is the double chloride of gold. Whisky is allowed *ad libitum*. Now, we believe this treatment to be irrational and unphysiological. It is a fundamental principle in the therapeutics of any disease, without exception, first of all things, to remove the cause, if it can be ascertained. The Keeley method disregards this entirely. Furthermore, the inebriate's nervous centres want and demand, in order for a cure to be effected, physiological rest, and an environment which places him in the most favorable condition for recovery. Manifestly these indications can best be obtained—only be obtained—in an institution especially equipped for this purpose. As Dr. Crothers puts it: "Drunkenness must be recognized as a disease legally, and the victim forced into conditions where he can live along the best sanitary lines of health; where medical treatment and control can be exact and perfect; and where physiological and hygienic training in its broadest and best sense can be applied."

Who can fully estimate the benefits to society, to morals and to civilization by promptly isolating such persons and keeping them in normal states of living?

The curability of the inebriate is far more certain than that of the insane. The liberty of both is equally dangerous: one is recognized; the other is seldom restrained until he becomes a criminal. The inebriate is mentally and physically sick, and

needs the same help as the insane ; and the question of care is simply one of adequate means and remedies to reach the disease.

Only one word more. It is interesting. In the October number of the *Review*, above quoted, is a rejoinder from the pen of one of the apostles of this great benefactor, Dr. Keeley. Col. John Flavel Mims, LL. D., better known as "Felix Oldboy," was once numbered among the transgressors, and from his own confessions his case must have been, at one time, a desperate one. But his salvation was finally obtained, at Dwight, Illinois, in the "potent" influence of the impotent chloride of gold. He was reclaimed and redeemed, and with becoming gratitude, but unbecoming haste, he prepared the article to which we have alluded. We quote :

"No one who has not been similarly cursed with the disease of drink can know the joy of the moment in which my cure came to me as a fact. I do not believe—I know—that I am cured, and am satisfied as to its permanency. I do not understand the processes, but I know the fact. To-day I meet my fellow man with open gaze, knowing that I have conquered the black lion of the desert ; and my sense of freedom and happiness no man can paint."

Unfortunately, however, before this eloquent tribute from the pen of Felix Oldboy had been issued from the press, and therefore before it had been read by the public, this same Col. Mims, or what was left of him by a cruel irony of fate, was fished out of the gutter in New York and carried to Blackwell's Island, where he promptly died the drunkard's death.

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We are indebted to Messrs. Lea & Shepard, of Boston, for their beautiful illustrated calendar, "All the Year Round." It is mounted with rings and chain, and makes an exceedingly neat and artistic design.

## “BRIGHT’S DISEASE.”

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In the *American Journal of the Medical Sciences* for October last an exceedingly valuable contribution is made by Dr. Francis Delafield, of New York, to the classification of the Diseases of the Kidney. Dr. Delafield has devoted years of patient study to these diseases, and his classification, the outcome of his labor, is both rational and convenient, and well worthy of adoption.

He proposes to discard the term “Bright’s Disease,” as misleading, and to classify renal diseases according to the nature of the morbid processes. There are three morbid conditions to which the kidney is subject—congestion, degeneration and inflammation.

Congestion of the kidney is an accumulation of blood in the veins and capillaries of the organ, and depends upon causes which affect the circulation.

Degeneration of the kidney is a secondary process, produced by inorganic poisons, as arsenic, or the poisons of infectious diseases, etc. The only change is in the renal epithelium, which becomes swollen and granular, perhaps disintegrated.

Inflammation of the kidney is attended with three essential features: an escape of the elements of the blood from the vessels, a formation of new tissue, and a death of tissue. The inflammations of the kidney are subdivided into: 1, acute exudative nephritis; 2, acute productive or diffuse nephritis. 3, chronic productive or diffuse nephritis, with exudation; 4, chronic productive or diffuse nephritis, without exudation. There are also suppurative and tubercular nephrites. Exudative inflammation is of short duration, leaving behind no permanent changes in the parts affected, and can be favorably affected by treatment. Productive inflammation runs an acute, sub-acute or

chronic course, and effects permanent changes in the inflamed parts.

Such a classification as the above brings with it a rational system of therapeutics. Acute congestion of the kidneys can be relieved by the application of heat to the surface of the body. Acute and chronic degeneration are conditions which we are unable to treat. In acute exudative and acute diffuse nephritis the indication is to diminish the severity of the nephritis and to regulate the circulation. For the former, cups or heat are employed over the lumbar region or the entire body, and calomel, sulphate of magnesia, opium, aconite or digitalis are used internally. The disturbances of the circulation are the causes of the dropsy and cerebral symptoms. With a laboring heart and contracted arteries drugs should be used which dilate the arteries—chloral hydrate, nitrite of amyl, nitroglycerine—or the quantity of blood may be diminished by venesection, sweating or purging. With a feeble heart and relaxed arteries cardiac stimulants are indicated.

In chronic nephritis, climate and mode of life constitute the important parts of the treatment; it is doubtful if drugs exert any effect in the nephritis. A warm, dry climate and an outdoor life are of the greatest importance. Medical treatment may be employed with advantage for the relief of the anæmia, the dropsy and the disturbances of the circulation.

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The Second Cuban Medical Congress will convene in Havana, in January, 1892. The President will be Dr. Juan Santos Fernandez. The congress was organized two years ago under very auspicious circumstances.

## ATLANTA SOCIETY OF MEDICINE.

At the December meeting of the Society officers for the following year were elected. The retiring President, Dr. McRae, delivered his final address in which he reviewed the work done by the Society during his administration. For the present year the officers will be: President, Dr. W. S. Kendrick; Vice-President, Dr. J. A. Childs; Secretary, Dr. C. D. Roy; Librarian, Dr. J. D. Wilson; Reporters, Dr. R. R. Kime, Dr. L. B. Grandy and Dr. H. F. Harris.

The friends of Dr. J. McFadden Gaston are pleased at his having received the well-bestowed honor of being elected President for the ensuing year, of the Southern Surgical and Gynecological Association at its recent meeting in Richmond, Va.

The best remedy to loosen expectoration is muriate of ammonium, combined with some such remedy as syrup of squills. If dry plastic pleurisy be present, iodide of ammonium should be added as follows :

R.—Ammonii muriat.....ʒiiss.  
 Syr. scillæ.....ʒij.  
 Ammonii iodidi.....ʒiss.  
 Glycerinæ.....ʒss.  
 Syr. prun. Virg.....q. s. ad. ʒiv.

M.—Sig. ʒj every three hours in water.

At the same time in a case of pleurisy, to prevent any possible tubercular tendency, give something to build up tissue and aid general strength; something to strengthen the chest. The best thing for this purpose is the syrup of the hypophosphites, ʒi three times a day after meals.—*Anders.—Ex.*



## Selections.

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THE MODERN TREATMENT OF SYPHILIS.—Acting upon the general knowledge that if carefully used mercury scarcely ever does harm, and that it often in chronic maladies, whether syphilitic or not, acts beneficially, I have, in common I suppose with many others, for long been in the habit of prescribing mercury in cases of ataxia. Very frequently patients appear to be greatly benefited by it ; more especially the severity of the pains and the tendency to gastric crises appear to be mitigated. I must confess, however, that I have never had in any single case anything which might be vaunted as a cure. If I were to quote the cases in which white atrophy of the optic nerves has occurred as a complication, I am afraid I should be obliged to confess that they have all advanced to blindness in spite of the remedy. It has not, however, been so in those cases in which *ophthalmoplegia externa*, or paralysis of single muscles of the eyeball have been the complicating condition. In nearly all these great benefit has appeared to result from the long continued use of specifics. In these latter, the iodide of potassium, as well as mercury, is often very beneficial, whereas in locomotor ataxy itself I think I have often seen it prove definitely prejudicial, depressing the patient's vigor and making him feel low-spirited and miserable, without in any way mitigating his symptoms. In general paralysis of the insane, if there is a history of syphilitic antecedents, I would never omit the long-continued use of mercury. I have seen great benefit from its employment, and when we remember that its most common pathological condition is adhesion of the pia mater to the gray matter of the convolutions (implying the existence of a low form of inflammation), we may easily believe that if not required as a specific mercury may still very possibly be of use. It should be given as a long course of small doses. I have not as yet adverted to the treatment of syphilis in its inherited forms.

In infants, inunction is easily practiced in a variety of ways, and is usually very effectual. I have also found a solution of the bichloride, in small doses, a very efficient remedy, and not so liable to purge as the gray powder. If there is any evidence of bone disease, the iodide of potassium should be combined with it. If the symptoms are severe, and especially if the viscera are involved, infantile syphilis is undoubtedly a dangerous disease, and apt to terminate fatally by marasmus or convulsions. If, however, the specific is well borne, and the child passes favorably through the secondary stage, then I think there is, as a rule, very little danger of relapse; and a condition of good health may be expected until at a later period, say eight to fifteen years of age, the liability to keratitis, deafness, phagedænic affections of the throat, etc., may come on. These late manifestations of inherited taint occupy in reference to treatment a most exceptional position. Although we always prescribe specifics, they seldom or never appear to exercise any definite power. Keratitis will often run its course apparently almost uninfluenced, or the second eye may be attacked while the patient is under the remedies employed for the cure of the first. As regards the deafness, unless the remedies are used in its very earliest stage, I fear they very seldom prove of any value. It is certainly to be strongly urged in reference to both the deafness and the keratitis that mercury and iodides should be prescribed promptly and liberally, but we must be prepared to encounter much disappointment and to forego all hope of the rapid cures which the same remedies often effect in other conditions. It may be well that we should remember, in reference to this class of maladies, that they occur in those in whom probably the syphilitic virus has long ceased to be active, and who would be quite incapable of conveying the disease by contagion. They are tissue maladies, not the result of existing blood-poisoning. Hence, probably, in part, the impotence of mercury to manifest its specific power. There is no microbe left for it to kill.—*Jonathan Hutchinson, in The Practitioner.*

THE INDICATIONS FOR EARLY LAPAROTOMY IN APPENDICITIS.—Dr. W. W. Keen, of Philadelphia, agrees with those who hold that so-called “perityphlitic abscess” is almost always due to appendicitis (Reprint from the *Transactions of the Medical Society of the State of New York*, 1891.) For clinical purposes five forms of appendicitis are recognized by this surgeon: (1) a mild and non-perforative form, ending usually in resolution without suppuration; (2) perforative appendicitis followed by general peritonitis; (3) the most common form, in which the appendix is perforated and a local abscess forms more or less rapidly, which, if left to itself, ruptures externally or into a hollow viscus, and finally ends within a few weeks either in resolution or the death of the patient; (4) a class in which the abscess forms slowly and follows a chronic course, lasting for months before it either discharges or indicates an operation; (5) recurrent appendicitis, in which attacks are repeated at longer or shorter intervals. The first class of cases—that of mild appendicitis—may, Dr. Keen holds, be dismissed from consideration as not requiring operative treatment save in exceptional cases. Cases of the second class—in which perforative appendicitis is followed by acute general peritonitis—demand instant laparotomy. No cases in surgery—except, perhaps, those of hæmorrhage from large wounded vessels—require more prompt interference. The indications for immediate recourse to laparotomy in such cases are: brief symptoms of recent appendicitis, or of one or more recurrent attacks, followed by sudden excruciating pain over the whole abdomen, but most severe in the right iliac fossa, with the easily-recognized symptoms of general peritonitis and impending collapse. In cases in which perforative appendicitis takes for a time a mild course, and does not, until after an interval of some weeks, break out into general peritonitis, there is likely, in consequence of the deceptive mildness of the attack, to be much doubt as to the proper treatment. Dr. Keen thinks an exploratory operation should be undertaken when there is persistent pain and tenderness, with even slightly increased resistance without any tumor, and with possibly slight œdema and moderate fever. Many of these cases, Dr. Keen believes, may be included

in the third class, in which an abscess—not, perhaps, of large size—has slowly developed, and at last has suddenly burst into the peritoneal cavity. Although there is occasionally much difficulty in distinguishing cases of this kind from those which run a continuously mild course and terminate in resolution, it is not impossible, it is held, to determine whether an abscess has formed or not. Dr. Keen relies mainly on local signs, which he regards as far superior to general constitutional symptoms. Even the temperature of the body may be a very deceptive guide, as this may be low while the local process is advancing towards a dangerous or fatal issue. He would lay it down as a rule, therefore, that even in mild cases, if the indications point even slightly towards suppuration, an early operation should be practiced. An exploratory operation, it is asserted, “carries with it less danger than the disease,” and no patient should be allowed to run the risk of probable or possible rupture and of general peritonitis. The most reliable symptoms of a localized abscess are pain and tenderness in the right iliac fossa, especially marked at what is called “McBurney’s point,” which is situated one and a half or two inches from the anterior superior spine of the ilium, in a straight line towards the umbilicus, and œdema of the groin. If these signs be present, together with nausea and vomiting, rigidity of the abdominal wall on the right side, and fever, an exploratory operation should be performed on the second or third day. If no pus be found, the vermiform appendix should be sought for, and if, as Dr. Keen believes will almost uniformly be the case, it be found thickened, distended, occupied by a concretion, or otherwise abnormal, even without perforation, it should be tied and cut away.—*Brit. Med. Jour.*

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VERY HIGH TEMPERATURE. —In the *Memphis Medical Monthly* for October, Dr. Heber Jones records his remarkable case of hyperpyrexia which excited no little interest and comment some months ago. Beginning at  $109^{\circ}$ , when first observed by Dr. Jones, the fickle mercury oscillated up and down the shaft of the thermometer all the way from  $96\frac{1}{2}^{\circ}$  to  $157^{\circ}$ . At

this point the instrument was broken by the expansion of the mercury, which, unfortunately, leaves us in ignorance as to how high the temperature might have gone. It might possibly have eclipsed the remarkable case of Dr. Gailbraith, who once observed a temperature of  $171^{\circ}$ .

Dr. Jones' patient was a girl of fifteen, not of nervous temperament, who had always enjoyed average health. This illness began with a tonsillitis which was not severe, lasting about one week. The above extraordinary play of temperature then developed, and covered a period of about six weeks. Nineteen thermometers were broken during the observations by the expansion of the mercury. Girl would not have practiced deception. During the paroxysms the subjective symptoms were intense; coldness, requiring half dozen blankets, hot bags of water, etc.; nausea, and at times vomiting. She also complained of "numbness," beginning in the face and extending to the body. The objective signs were pallor and lividity of face and extremities, these appearing cold, and the body warm but not hot. The tongue was generally coated, but rarely dry. The pulse never ran over 120, and was generally under 100. The urine was normal, examined both chemically and microscopically, and nothing worthy of note found. Digestion impaired, bowels inclined to constipation, but no serious trouble; menstruated normally during the attack. At times, some tenderness in splenic and hepatic regions. At one time developed considerable tenderness in right iliac, and along the ascending colon—lasted about a week. Convalescence rapid, and she has since enjoyed perfect health.

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TREATMENT OF PNEUMONIA.—In the *Medical Record*, December 5, Dr. A. A. Young, Newark, N. Y., commends the use of jaborandi in pneumonia. There is a relation, he says, between the urea or urates of the system and the pneumonic poison, and the severity of the malady can almost be measured by the abundance of urates present. To diminish the amount of these urates is the object of the jaborandi treatment. The drug produces, in a few minutes after its administration, flushing of the face and

skin, quickly followed by profuse perspiration and intense salivation, which usually lasts from two to four hours. Drug does not depress the heart, and is slightly narcotic. Amount of urine is greatly increased, and contains urea in abundance. Method of administration is to give one-fourth grain of pilocarpine, the active principle of jaborandi. If this should not produce perspiration in one hour, one-eighth grain more is to be given. Adjuvants, as carbonate of ammonia, or sparteine, or whisky, are given, as indicated. Under this treatment the urea is eliminated, the temperature falls, the pulse and respiration are reduced in frequency and the general well-being of the patient subserved. The writer does not claim originality for this method. The reported success of this treatment in his experience for a period of six years may well encourage others to try the same plan.

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MEDICAL PRACTICE IN CONNECTICUT.—The following spicy delineation of the medical situation in Connecticut is taken from the *Bulletin of the Connecticut Board of Health*: “SIR: Anybody can practice medicine in Connecticut. You do not need to register; you do not need a medical diploma; you do not need to know the difference between opium and peppermint; you do not, indeed, need to know anything. You can simply come and live here and begin to practice. The laws of Connecticut will sustain you in collecting your fees for professional services, if you render any which you choose to call such. But if you undertake to carry me or my trunk to the depot for pay, you must get a license. If you peddle matches or peanuts, you must get a license. If you collect the swill from your neighbors, to feed your pigs, you must get a license. If you want to empty your cesspool, you must get a license. But you can practice medicine in Connecticut *without a license*.”—*N. Y. Med. Journal*.

QUERY:—“How is it in Georgia?”

## Book Reviews.

**PTOMAINES OR LEUCOMAINES.** By Victor C. Vaughan, Ph. D., M. D., Professor of Hygiene and Physiological Chemistry in the University of Michigan and Director of the Hygienic Laboratory, and F. G. Novy, Sc. D., M. D., Assistant Professor of Hygiene and Physiological Chemistry in the University of Michigan. Lea Brothers & Co., Philadelphia.

This being the first work collecting and dealing with chemical factors in the causation of disease, it may well be considered the pioneer work in that line.

Emanating from so high authority and dealing with the intricate problems of the causation of disease, it cannot help but contain much that is interesting to the student of scientific medicine, and he who searches for the pathogenic causes of disease cannot fail to be profited by a study of its contents.

The authors endeavor to show that the "Mechanical Interference Theory" of Bacteriology is inadequate, and ably advocate the theory of alkaloidal developments as a cause of disease.

That bacteria are toxicogenic or non-toxicogenic according as their chemical products are toxic or non-toxic.

We are impressed by a brief review of the work that it is not so much a study of the morphology of microbes as a study of their toxic chemical products that will lead us into the light of the causation of disease. That the pathogenic quality of a germ depends upon its capacity to elaborate a chemical product of greater or less toxic properties.

The chemistry and chemical relations of bacterial products occupy a considerable part of the book, concluding with a chapter on Autogenous Disease, which is very interesting and instructive.

If one desires to be conversant with the latest views and discoveries in this line we would advise a study of this work.

R. R. K.

**POCKET MEDICAL FORMULARY.** By W. M. Powell, M. D., author of "Essentials of Diseases of Children"; Attending Physician to Children's Clinic at University Hospital, Philadelphia, etc. Philadelphia. W. B. Saunders.

This formulary does not differ materially from others which have been compiled. All are mere collections of prescriptions which have been found valuable in given conditions, from time to time. This one, which is as good as any other, is supplemented with an appendix containing a posological table, formulæ and doses for hypodermic medication, a diet list for various diseases, etc.

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## Original Communications.

### ABDOMINAL SECTION IN A CASE OF CYST OF THE MESENTERY, WITH REMARKS.\*

By J. ADRIAN GOGGANS, M. D., ALEXANDER CITY, ALA.,  
Member of the Board of Medical Examiners of Tallapoosa County; Senior Coun-  
sellor of the Medical Association of the State of Alabama; Fellow of  
the Southern Surgical and Gynecological Society; Fellow  
of the British Gynecological Society.

I have been induced to write this paper from the fact that cysts of the mesentery are extremely rare, and operations for their removal have proven to be most generally fatal. Delagenière<sup>1</sup> presented specimens of a tumor of the mesentery to the Anatomical Society of Paris, removed from a patient by Guyon. The patient was a woman forty-five years of age, suffering from epilepsy. The tumor occupied the left hypochondriac and

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\* Read before the Southern Surgical and Gynecological Society in Richmond, Va., November 12, 1891.

<sup>1</sup>J. Ewing Mears: Sajous' Annual of Universal Medical Science, Vol. iii.



lumbar regions, and was as large as a foetal head. It was increasing in size, and caused such abdominal pains that Guyon decided to remove the fluid by aspiration. He removed thirty-two ounces of a brownish fluid which contained albumin, urea, phosphates and chlorides. Within two weeks after the aspiration the tumor had increased to the size it had attained before the operation, and the patient suffered such pains that Guyon decided to open the abdomen and attempt to remove the cyst. After opening the abdomen, he removed by aspiration twenty-eight ounces of fluid, and upon examination the cyst seemed to originate in the meso-colon. It was finally enucleated, after having ligated many large blood-vessels. The patient died on the seventh day after the operation. Sir Spencer Wells<sup>2</sup> has performed two operations for tumors of the mesentery; one of them was solid, and the other was cystic. He incised and drained the cyst, but the patient died within a few weeks after the operation. The solid tumor was successfully removed by enucleation. Greig-Smith<sup>3</sup> mentions seven cases of lipoma of the mesentery, in which operations were performed for their removal. He describes them as follows: Terrillon<sup>4</sup> presented a patient to the Academy of Medicine of Paris, from whom he had removed lipoma of the mesentery by enucleation. Homans<sup>5</sup> has performed two operations for the removal of lipoma of the mesentery. One of them was a male, thirty-nine years of age. His first attempt to remove the tumor in this case was a failure, but a successful operation was performed some months afterward. The patient finally died from shock. The second case was that of a woman sixty years of age, in every way similar to the first case. This patient likewise died from shock. Dr. Calvin Ellis, according to Homans, had a similar case. Three cases of lipoma of the mesentery are described in the *Transactions of the Pathological Society of London*. And Cooper Forster<sup>6</sup>, in

<sup>2</sup>Lancet, May 5, 1883.

<sup>3</sup>Greig Smith: Abdominal Surgery.

<sup>4</sup>Journal of the American Medical Association.

<sup>5</sup>Lancet, 1883, p. 449.

<sup>6</sup>Greig-Smith: Abdominal Surgery.

1868, showed a large fatty tumor at the Pathological Society of London, removed from a woman after death. Pèan<sup>7</sup> describes three operations for cystic tumors of the mesentery, with only one success. Watts<sup>8</sup> describes another operation for cyst of the mesentery. In this case the tumor was mistaken for an ovarian cyst. Carter<sup>9</sup> likewise described an operation for the removal of a cyst of the mesentery in a female patient forty-four years of age. It was of two years' growth, and contained sixteen pints of fluid. The attachments of this cyst to the spine and lumbar region were so firm, and it was so closely encircled by coils of the small intestine, that the attempt at its removal was abandoned. The operator then incised and drained the cyst, and stitched the incised lips of the cyst to the abdominal walls. The patient finally died from septicæmia and hemorrhage. Greig-Smith<sup>10</sup> says that he knows of two cases of cyst of the mesentery in which operations were performed for their removal by his friends, but that they have not yet been published.

Dr. Granville Bantock describes a case of cyst of the mesentery in which the tumor was about the size of a Mandarin orange. It was in a young girl fifteen years of age. She sometimes had a temperature of 105° F. Sir Joseph Lister agreed with Dr. Bantock as to the necessity of its removal, and, consequently, the operation was performed on February 16, 1886. An incision was made in the abdomen, along the outer border of the rectus muscle. The tumor was covered by the mesentery, whose blood vessels were enormously enlarged, and it lay in close proximity to the left kidney, for which it was mistaken. Many ligatures were required, a drainage-tube was inserted, and the patient made a tedious recovery. The tumor weighed one pound, and is now in the Museum of the Royal College of Surgeons. Mr. Eve made the following report on this tumor: "I am quite at a loss to explain its origin. The tumor

<sup>7</sup>Tumeurs de l'Abdomen.

<sup>8</sup>American Journal of Obstetrics, 1879.

<sup>9</sup>British Medical Journal, January 6, 1883.

<sup>10</sup>Personal communication.

<sup>11</sup>Personal communication and Lancet, 1887.

is composed of a number of intercommunicating loculi, separated by numerous septa, and containing a glairy fluid. The situation being so unusual, I conjecture that it originated from some foetal structure—possibly some of the rudiments of the permanent kidney. It was too high up for the Wolffian body. The other possibilities that occur to me are, that it was an ovarian cyst which had become separated by twisting of pedicle, or that it was of the same nature of cysts that appear in the great omentum." Dr. Bantock says: "I take Mr. Eve's first explanation as being the probable correct explanation of the origin of this tumor. It was situated too much behind the mesentery for an ovarian tumor which had been separated from its attachments."

The patient upon whom I operated for a mesenteric cyst was Miss S. L. M., aged twenty-one years, daughter of a physician of Columbus, Ga., fair complexion, and weight, when in health, one hundred and twenty pounds. Family history good. I saw her for the first time on February 7, 1891. She stated to me that she had been out of health for about two years, but referred the beginning of her abdominal trouble to a cold which she contracted while in New Orleans about May, 1890. It was not until November or December, 1890, that she called her father's attention to the fact that her abdomen was becoming larger. She had been seen by several physicians, and treated for abdominal dropsy. At the time of my first visit, her abdomen was quite large, her pulse 110 per minute, and temperature 100° F. I made the diagnosis of an abdominal cyst, the tumor occupying mostly the left side of the abdomen, extending from under the ribs into the left lumbar region, dipping down into the pelvis, and extending three inches to the right side of the median line of the abdomen into the right side. I decided to remove some of the fluid by aspiration for examination, and did remove about one quart. It was a thin, dark-colored fluid, and contained albumin phosphates and chlorides. I saw her again on February 13, 1891. She had suffered much pain, accompanied by nausea and vomiting, and was more prostrated than before the operation. An operation for the removal of the tumor

was proposed, and she readily consented to have it performed, February 24, 1891, being the day selected for the operation. In the meantime I asked my friend, Dr. W. E. B. Davis, of Birmingham, Ala., to see her with me, and assist me with the operation. Consequently, he saw her on February 24th. Upon examination he concurred in the opinion that an abdominal cyst existed, but we were unable to explain its origin and attachments.

The operation was performed with the assistance of Dr. Davis,<sup>1</sup> Dr. J. W. Mitchell, of Hamilton, Ga., and Dr. T. S. Mitchell and Dr. Phillips, of Columbus, Ga. The strictest antiseptic measures were carried out. The abdominal incision was made in the linea alba, extending two inches above and two inches below the umbilicus. On introducing the hand, it was evident that the attachments of the cyst were high up in the abdomen and in the region of the left kidney. The left kidney, however, was easily recognized. The walls of the cyst were covered with omentum. Many large blood vessels and several loops of small intestine were encircling it, being deeply imbedded in the walls of the cyst. An attempt to enucleate the cyst was followed by such profuse hemorrhage that the idea of enucleation was abandoned. Consequently, a point on the walls of the cyst, as remote as possible from blood vessels and loops of intestines, was selected for incision and drainage; more than a gallon of dark, thin-colored fluid was evacuated. The cyst was then irrigated with hot water, its incised lips stitched to the upper angle of the abdominal incision, an ordinary six-inch glass drainage-tube introduced to the bottom of the sac, and the abdominal incision closed with silk-worm-gut sutures. The general direction of this tube was upward and backward. From the appearance of the sac and its deep attachments, both Dr. Davis and myself came to the conclusion that it was retro-peritoneal. In other words, that the cyst was between the layers of the mesentery. The time consumed in performing the operation was about twenty-five minutes. On the morning of the operation the

<sup>1</sup> I wish to express my sincere appreciation of the skill and invaluable assistance rendered me by Dr. Davis during this operation.

patient's pulse was 120 per minute, and temperature  $100^{\circ}$  F. She came out from the anæsthetic well, and at 10 P. M. of the same day her temperature was  $100\frac{3}{4}^{\circ}$  F., and pulse 130 per minute.

*February 25.* 7 A. M., temperature  $99^{\circ}$ , pulse 104. 6 P. M., temperature  $99\frac{1}{4}^{\circ}$ , pulse 110.

*26th.* 7 A. M., temperature  $98\frac{1}{2}^{\circ}$ , pulse 110. 6 P. M., temperature  $100\frac{1}{4}^{\circ}$ , pulse 106.

The fluid has been drawn from the sac at intervals of three or four hours, and the sac thoroughly irrigated with warm water. Gave an enema of warm water, and the bowels have moved well.

*27th.* 7 A. M., temperature  $99\frac{1}{2}^{\circ}$ , pulse 104. 10 P. M., temperature  $99\frac{1}{2}^{\circ}$ , pulse 110.

*28th.* 7 A. M., temperature  $100\frac{1}{4}^{\circ}$ , pulse 112.

*March 1.* 7 A. M., temperature  $98\frac{4}{5}^{\circ}$ , pulse 96.

Has had much nausea and vomiting from time of operation until March 1st, much of which I attribute to the intimate connection between the walls of the cyst and the small intestines. She is now taking a little food. The sac is being irrigated daily, and the drainage-tube being gradually withdrawn.

*2d.* 7 A. M., temperature  $98\frac{4}{5}^{\circ}$ , pulse 100.

*3d.* 7 A. M., temperature  $98\frac{4}{5}^{\circ}$ , pulse 94. 8 P. M., temperature  $98\frac{1}{5}^{\circ}$ , pulse 96.

*5th.* 7 A. M., temperature  $99^{\circ}$ , pulse 96. 6 P. M., temperature  $99\frac{2}{5}^{\circ}$ , pulse 100.

*8th.* 6 A. M., temperature  $98\frac{1}{2}^{\circ}$ , pulse 100.

Passed a restless night last night.

*9th.* 6 A. M., temperature  $98\frac{3}{5}^{\circ}$ , pulse 90. 6 P. M., temperature  $99\frac{1}{2}^{\circ}$ , pulse 100.

Has been quite sick to-day. Suffered from severe pain in the locality of the pedicle, which continued for two or three hours, and was followed by nausea and vomiting. Glass drainage-tube was removed, and a small rubber tube introduced.

*10th.* 8 A. M., temperature  $98\frac{3}{5}^{\circ}$ , pulse 90. 6 P. M., temperature  $99^{\circ}$ , pulse 92.

*11th.* 8 A. M., temperature  $99\frac{1}{2}^{\circ}$ , pulse 90.

*15th.* 8 A. M., temperature  $98\frac{4}{5}^{\circ}$ , pulse 76.

*20th.* 8 A. M., temperature  $99\frac{4}{5}^{\circ}$ , pulse 100.

24th. 8 A.M., temperature 99°, pulse 100.

25th. 8 A.M., temperature 98½°, pulse 100.

Was taken with pain in the region of the pedicle at 10 A. M., on 24th, and vomited at intervals of two or three hours until this morning. She is now quite comfortable.

30th. 8 A. M., temperature 98½°, pulse 76. From this time she made a perfect recovery.

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## CLINIC REPORTS.

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REPORT OF CLINIC OF W. F. WESTMORELAND, M. D.,  
Professor of Principles and Practice of Surgery,  
Atlanta Medical College.

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GENTLEMEN—We present to you to-day two cases for operation, one an amputation of the forearm, the other an amputation of the breast. The history of these patients you are already acquainted with. Before beginning these operations, I wish to impress upon this class the great importance of the primary details and dressing as regards the successful progress of a case after an operation, and that by thoroughly carrying out the details of antiseptic surgery, particularly in reference to the immediate field, you can operate under the most adverse circumstances, and have primary union without any process of supuration.

Antiseptic surgery has been surrounded by so many details, the technique that is claimed as absolutely necessary is so difficult to carry out that student, and general practitioner, is apt to consider its accomplishment beyond his ken; that it may be achieved by surgeons in special hospitals, but impossible in the hands of the surgeon from house to house—a palace to-day, a hovel to-morrow.

There could be no worse surroundings than we have in this amphitheatre where we expect to operate to-day. The room is crowded with students all day, used by the professors of each

different branch to exhibit their patients, bringing together within these walls people suffering from every imaginable disease. Less than an hour ago, a cadaver, in the last stage of dissecting, was demonstrated before you here. In addition to these general surroundings, both the cases we expect to operate upon have had long continued suppuration. We have prepared for these operations before the class, so you watch all the different stages.

A fountain syringe, filled with hot bi-chloride solution (1-2000) is hung within easy reach, four basins filled with the same solution are placed near at hand; into the first we place half a dozen towels; in the next, the sponges taken from a jar of carbolized solution (1-20) where they have been kept pure; the solution in the remaining pans is used by the operator and assistants for washing their hands. The instruments are placed in a pan containing carbolized solution (1-40). Several sizes of cat-gut, which will be used as sutures and ligatures, are in alcohol in this bottle. The patients have been prepared by the parts surrounding the field of operation being thoroughly scrubbed with nail brush and soap; the hair is shaved off; a sponge saturated with ether will remove all the oily secretions that may have found lodging around the edges of the fistulous tracts. Now wash with bi-chloride solution (1-500) and rinse with milder solution (1-2000) and put on an antiseptic dressing or towels wrung out of bi-chloride solution to keep the parts pure until time of operation.

*CASE I.—Amputation lower third forearm, for arthritis of the wrist joint.*

The patient has had long continued suppuration and the bones of the joint are now disintegrated, the distal ends of the ulna and radius being involved.

The patient is now anæsthetized, so we will proceed with the operation. My own hands and those of the assistants are thoroughly scrubbed with a nail brush and soap, then rinsed in the pan of bi-chloride solution. The patient's arm is doused with the same solution, and protected by having towels from bi-chloride solution placed around it. Esmarch's bandage for the

bloodless operation is applied. We amputate by the circular flap; ligate all vessels with cat-gut before removing the bandage. The wound is now ready to be closed. This is done by bringing the edges together with a continuous cat-gut suture. Now, we come to the very important point of drainage. You see we have made an incision through the flap on the outer side and another on the under surface of the arm. Instead of using drainage tubes, which many of you will never keep, we will retrovert the edges of the incisions and stitch them back with cat-gut. This insures perfect drainage. After the cavity is washed out thoroughly with a stream of solution from the fountain syringe, the dressing is applied. This consists of a number of layers of bi-chloride gauze smoothly applied and carried as high as the elbow. This is held in position by a bandage of the same material, only slight pressure being made. The arm is now enveloped in a moderately thick layer of borated cotton, which is held by a firmly applied bandage. We now put the arm on a well padded straight split to insure perfect rest. Last of all, we put on a starch bandage, which, when dried, holds the dressings firmly in position and prevents any slipping.

*CASE 2.—Amputation of breast for non-malignant tumor, in a stage of suppurative inflammation, with numerous fistulous tracts. Axillary glands not involved.*

Patient prepared in the same manner as the previous one. The breast removed by an irregular incision so as to include the fistulous openings, wound closed by continuous cat-gut suture; an incision made at the most dependent angle of wound, edges of the incision retroverted and stitched as in previous case. Same dressings used and arm bandaged to side to give perfect rest.

When we finished dressing these cases, the fate of the wound as to whether there would or would not be suppuration was settled, as it always is, with the first dressing. I have not noticed any omission of antiseptic precautions and feel that I can say positively, that we will have primary union without any suppuration, although the surroundings are bad and the condition of the patients still worse. Occasionally during the operation a stream



of solution was allowed to play on the operative field; the wound was thoroughly washed immediately before the dressing was applied. We made ample drainage, and put on a dressing that will give perfect rest. So the three essentials of antiseptic surgery, antiseptic details, perfect drainage and complete rest, were carried out.

As to the complaint that it makes a much longer operation, my best answer is that it has taken slightly over a half an hour to make these operations and dress the patients, part of which time was occupied in removing our patient and bringing in the other.

Everything we have used in these operations is easily procured, and can be carried to the bedside of your patient in a satchel.

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REPORT OF CLINIC OF A. W. CALHOUN, M. D.,  
Professor of Diseases of Eye, Ear and Throat, Atlanta Medical College.

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REPORTED BY JAS. H. LATIMER, JR.

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I. G. E.: White, male, age twenty.

Diagnosis: Ulceration of cornea, deposit of albuminate of lead on cornea of both eyes.

#### REMARKS.

Patient had probably had purulent ophthalmia and as a result ulcers of the cornea.

Doubtless the condition had been treated with acetate of lead, which, coming in contact with the albuminoid secretions of the eye, had formed an insoluble albuminate of lead, which was deposited on the cornea.

Dr. Calhoun said that he was glad of an opportunity of presenting a case of this character before the class, as it was one of the many instances in which a physician had injudiciously used acetate of lead in eye troubles, stating that while acetate of lead is one of our best astringents, it should never be used in eye

troubles, especially where there is danger of ulcers, as invariably we would obtain just such results, which, besides ruining our patient's vision, would be a living monument of our unthinking treatment; and that while the ulcers may not be present at the time we make our diagnosis and prescribe, the possibilities are that they would creep out at any time, our patients awaking some morning with an abscess or an ulcer, and as a sequela these deposits, and as there are other astringents that will obtain for us the results wanted without this danger of a deposit, it is bad practice to use it.

The patient was given a solution of atropia (2 grs. to ounce) to allay pain and inflammation and cantharidal blisters applied to temples as counter-irritants, and instructed to return, when we will curette, and scrape off as much of the deposit as possible, and may be able to make pupil clear. If can't make pupil clear will make an iridectomy.

\* \* \* \* \*

R.L.S.: White, male, age twenty-seven years, resides in Atlanta, Ga. Appeared before class Oct. 8th, 1891, claiming to have had secondary symptoms of syphilis before primary lesions appeared; was treated for syphilitic sore throat, even before chancre made its appearance. He claims it was three months after these lesions before the chancre appeared. The chancre covered the entire glans penis and a caustic was applied. About the same time acute articular rheumatism of ankles, also muscular rheumatism in left arm appeared. Patient gave no history of rheumatism in parents. Had been treated by several physicians for *Rheumatism*, but grew worse; suffering more in changeable weather, much worse at night than at day, not abating at all until antisyphilitic remedies were resorted to. Right hand in the meantime had become swollen to the extent that could not hold a pencil, and at time he presented himself had not subsided. Patient had at the time he presented himself a beautiful crop of typical mucous patches covering entire soft palate and sides of mouth, which was accompanied with nystagmus of both eyes, also leuchoma on left cornea. Patient was immediately placed

on mercurial treatment. Proto-iodide of mercury was given, commencing with one-fifth grain doses three times daily. No treatment was directed for the other troubles.

Results: First week, mucous patches much better; dose was increased to two-fifths grain three times a day.

Second Week: Mucous patches better; increased dose by one-fourth grain three times daily.

Fifth Week: Continues to improve; ordered to continue same dose.

Sixth Week: About same as fifth, but three spiculæ of the hard palate had become necrosed and working through soft textures of hard palate into mouth, leaving openings through which a probe could be passed, touching the bone.

December 4th: Mucous patches were all gone, but the openings to palate bone were still open, but slightly healing.

December 17th: The openings were better, but they were still open; same treatment continued.

January 7th, 1892: About the same; treatment changed; was put on iodide of potash and mercury; saturated solution as follows:

R. Kalii iod., ʒss.  
Hydrarg. bichlo., gr. i.  
Tr. gentian,  
Aquæ aa. ʒi.  
M. Ft. sol.

SIG.—10 increased to 75 drops three times a day, largely diluted after meals.

January 14: Openings in roof not closed but improved; had a hordeolum on lower palpebra—opened and evacuated.

REMARKS: The nystagmus is in all probability congenital; could get no history of the leuchoma; it possibly is not the result of any cause due to syphilis, but to some corneal troubles, independent of syphilis.

Dr. Wm. L. Russell has recently been appointed to the position of Attending Physician in the Department for Diseases of the Heart and Lungs at Demitt Dispensary, New York.

## REPORT OF PERINEAL SECTION,

Performed by Dr. F. W. McRae before the Class of the Atlanta Medical College.

The operation for the relief of a stricture of the deep urethra "of the tortuous variety," caused by gonorrhœa. It was an old case of five years' duration, and had been treated about one year previous by gradual dilatation.

The operation was performed on October 31, 1891. The patient was a strong, healthy-looking negro named Geo. Wood, age twenty-three, occupation porter on train.

He had been taking boric acid, ten grains, three times a day for a week previously as preliminary treatment.

*Operation.*—Having anæsthetized the patient, the parts were shaven and washed with a bichloride solution, strength 1 to 2,000. He was then placed in a position for lithotomy. With an assistant to hold each knee in position, Dr. McRae, after many attempts, succeeded in passing a filiform bougie, upon which was passed a tunnelled catheter; then with a third assistant to steady the catheter, the doctor proceeded to cut down upon the end of the catheter, in the median line of the perineum, making an external opening of about an inch and a half in length, dividing carefully layer after layer, until the end of the catheter was reached, then enlarging the incision from below upward. Having his assistants to hold the wound open with retractors, with a probe-pointed tenotomy knife the doctor divided the stricture, posterior to the perineal opening, from before backward, using the filiform as a guide, until the urethra was enlarged sufficient to pass in a grooved director, which was then used to divide the stricture upon. A gush of urine followed the division of the stricture.

The division of the deep urethral stricture anterior to the primal opening was made in the same manner. That part of the stricture in the penile urethra was then divided with an Otis dilating urethrotome, first slitting the meatus with a meatotome.

The wound was then washed out with a 1 to 2,000 solution of

bichloride. A rubber catheter was then introduced through perineal opening into the bladder. The wound was then dusted with iodoform, dressed with iodoform gauze, bichloride gauze and absorbent cotton, in the order mentioned.

A T bandage was then applied to hold the dressing *in situ*. A piece of rubber tubing about two and a half feet in length was then attached to the catheter and the operation was finished.

The patient rallied well from the effects of the ether. The wound was dressed again on the second day after the operation and a bougie introduced. It was also redressed on the fifth day and the catheter taken out, at which time the patient had a slight chill. No urine was passed through perineal opening after the tenth day. On the twenty-eighth day of November, just four weeks after the operation, the patient was at the college, at which time the doctor introduced a No. 33 French sound without any difficulty whatever. He then dismissed the patient with instructions to introduce a bougie occasionally.

LUCIUS LAMAR,  
Reporter.

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### SOME REMARKS CONCERNING THE USE OF MERCURY IN THE TREATMENT OF SYPHILIS.\*

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BY DR. F. A. RIETEMA, ROTTERDAM.

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Translated for THE JOURNAL.

In the effort, at present noticeable, to bring a number of new remedies into the therapy of syphilis, it may not be amiss to inquire:

- (1) If the need of new remedies is actually so great as one would believe, considering the large addition; and
- (2) Whether the old remedies do not meet every indication in syphilis when properly employed.

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\*From Monatshefte für Praktische Dermatologie, Band XII, No. 12.—H.

In answer to these questions, we will now mention the methods of treatment customary throughout middle Europe. The inconveniences of the oldest of all methods of treatment (inunctions) direct us to the effort of trying to find other and better methods if possible, and even to a certain prejudice against this method, in consequence of which one looks at its defects through a magnifying glass while he overlooks or condones those of other plans. Is it fair to object to the inunction method that one does not know how much of the mercury "rubbed in" is taken up by the system? Is it just for Rossbach to say? "However, the simplest and best rule, that the physician should know how much of a strongly poisonous remedy is introduced into the system, cannot be followed with reference to the gray ointment, or how much of that taken up is rendered available through oxidation. And if one would reply that the greater part of the mercury is wasted in inunctions and only the smallest portion has effect, we might ask if that would be reason to order a remedy with directions to pour out ninety-nine parts and to take one part? No; for these objections hold also for the other methods, save hypodermic injections with soluble mercurials."

Does any one know what proportion of the at present so esteemed injections with emulsions of insoluble mercurials or mercury in substance enters the circulation? By no means. That which is taken up from the injections withdraws itself in every direction, whether the quantity  $x$  is taken up in one, ten or one hundred days, one does not know; nor, much the less, whether  $x$  is taken up in a space of  $y$  days; and just here is not only the defective, but also the dangerous side of the method of injecting insoluble mercurial salts into the organism.

Exactly because of that uncertainty as to absorption, one is exposed to the fear that quantities might be taken up in a short time which would produce extremely unpleasant symptoms, as stomatitis and intestinal disorders. If that happens, one stands completely helpless against it; while one can stop the mercury in all other methods, he cannot here, because there is a depot in the system from which absorption is constantly taking place. Excision of the site of injection will be almost an impossibility.

According to our opinion, those dangers make the method unconditionally objectionable (even if they were actually as rare as some prefer to specify, although far from all unfavorable occurrences reach the public). We should like to place their chance of occurrence at nothing, even if the other methods fell far short of its usefulness, which is by no means the case; for, at present, "the greater therapeutic effect" of injections with insoluble mercurial salts seems to become more problematic the longer they are used, but there are observers who think they have noticed the number and severity of relapses increased under this method. And even if one should doubt this, it is certain that the method does not act more rapidly, its single advantage being the convenience of its use. If, however, two bridges cross a river, one of which, though short and easy to cross, threatens every moment to fall, while the other, though longer and more difficult, is of far greater strength than the first, no novice, indeed, acquainted with the characteristics of both would dare to prefer and recommend the first. Certainly, every one would choose the second. That which is not allowed of the "novice" would certainly not be permitted in the physician.

I am, therefore, convinced that, in any event, we must give up the method which promises so little. It is now the fashion, and "the gods battle in vain against fashion." Here it must not be forgotten that the introduction of a new, insoluble mercurial salt for injection is an excellent means of getting a little reputation for learned gentlemen who have, as yet, none.

Theoretically there is nothing to object against the use of soluble mercurial salts. The procedure is rational; the intestinal canal is not affected; it permits accurate dosage; is as little fraught with the danger of producing abscesses if rightly employed as the use of the insoluble, and with it one can stop the mercury at any moment without fearing the cumulative effect of that previously injected, as in the case of the insoluble. The single objection to this method is that the patient must visit the physician daily or at least every other day. But this objection is so great in private practice that it forms the chief drawback in the use of this intrinsically valuable measure.

As regards the inunction method, a hundred years' experience has proven its value, and where, in medicine, Practice speaks Theory must be silent. Our view is that the inunction method, when well applied, is one of the best. Proper application alone leaves much to be desired. In hospitals and private institutions, where one has a well-trained staff and under his constant personal observation, the method acts excellently. It is different in private practice where the patient rubs himself, and, as a rule, the results are miserable. A common fault is that one does not rub long enough, and, further, the patient exercises too severely, producing sweating, which renders illusory any small effect which would be obtained from the too brief rubbing. In private practice we consider the inunction method but little capable of results.

We have believed ourselves able to establish our unfavorable judgment concerning the injection of insoluble mercurial salts, and we have seen that the, in every way proper, injections with soluble (mercurial) salts meet the difficulties of practice. It remains now to answer the question whether the yet to be mentioned method, the internal employment of mercurial preparations, meets all desirable requisites, both in theory and practice.

Among the Germans, especially, there exists a prejudice against this method, the cause of which is not easy to demonstrate. We order *per orem* the greater number of all medicines. Practice has taught how great the quantity shall be for man in any special case. For instance, no one has to estimate how much to give when quinine, digitalis, antipyrin, salicylate of soda, etc., are to be administered by the mouth, and yet one is quite content with results obtained. However, as soon as the procedure extends to the mercurial preparations, one must estimate somewhat, and does not seem to think or deny that a remedy, which has been used by millions of Romanish people for a hundred years, must possess undoubted peculiarities which justify that procedure, or it would be to deny all judgment to the Romans, and we should not like to do that. On the contrary, we hold this method (presupposing its rational em-



ployment) directly available everywhere as a curative procedure which fulfills every reasonable expectation.

One may say in general that there is expected of a remedy:

(1) With its use the symptoms vanish the most quickly.

(2) That either no, or the slightest possible, unpleasant appearances occur, and especially no effects which render questionable the results of its use.

Are there mercurial combinations which, used internally, meet both these requirements? I believe I can answer in the affirmative with complete truth.

In the round of practice the majority of physicians come to use special combinations, which gives the not to be underestimated advantage of knowing better what they may expect from their treatment in each particular case, over those who order the numerous mercurial preparations in succession. We employ preferably the tannate of mercury, corrosive sublimate or calomel—the latter especially in practice among children. In the first year and a half following infection we rarely use iodine and mercury combinations. The following is the plan of treatment:

The treatment is begun as soon as the symptoms of general infection show themselves on the skin. For reasons, the detailing of which would take us too far, we are absolute opponents of the method of beginning treatment while the "hard ulcer" exists alone, without further evidences of syphilis. As soon as the "roseola" appears the patient begins taking (about) one and a half grains of tannate of mercury three times a day, immediately after meals; the *ulcus durum* alone is treated with mercurial plaster, while the treatment is appropriately modified in cases where soft chancre complicates the hard.

The patient is instructed to keep the mouth scrupulously clean; nevertheless we have him avoid the too frequent brushing of the teeth and gums, which we permit at most only once a day, but advise the patient to rinse out his mouth with water immediately after eating anything. We believe the entirely too energetic brushing of the teeth less advantageous because we have noticed that patients who are not accustomed to cleaning their teeth then get the mucous membrane of the mouth into a

state of irritation which predisposes to stomatitis. When symptoms disappear fairly rapidly we continue the above treatment at least thirty-five days, because we believe it highly important that the first course of treatment should be as thorough as possible. If a mild salivation arises during that time it must be treated in the usual way. If none occurs the dose is somewhat increased until it does occur, as we believe slight salivation is evidence that the system is saturated with the drug.

If the symptoms (of syphilis) disappear in just thirty-five days the treatment must be kept up for fifty-three days, as we follow, the rule that it must continue one and a half times as long as the time required to produce complete disappearance of the symptoms. The somewhat increased stools, usual at first, soon return to normal or simply remain a little "watery" while diarrhœa seldom occurs and is easily controlled. We have not yet observed any other unpleasant symptoms.

Relapses are treated either with tannate of mercury or with the bichloride. With the latter the following is the plan: Of a solution of bichloride 1-1000 in distilled water, we have the patient take twenty-five minims ( $\frac{1}{4}$  gr.) diluted in a glass of water, three times a day, immediately after meals, and increasing the dose, according to slowness or rapidity of subsidence of symptoms, to double, hence  $\frac{1}{2}$  gr. of the bichloride.

I have never noticed any stomach or intestinal trouble in connection with this treatment, the slightly increased and easily controlled stools being the only effect. That corrosive sublimate has got the reputation of easily causing derangement of the stomach arises from the manner in which it is often used. However, one finds recipes recommended in the latest works upon syphilis, in which the drug is provided in pill form and increased doses, and this while twelve years ago we could read in Nothnagel's and Rossbach's book—after they had shown that sublimate undiluted was a corrosive substance: "The opinion that the stomach gradually gets accustomed to large doses of corrosive sublimate is as nonsensical as would be the belief that the animal body could finally get so as not to be burned with fire if one only gradually increased the degree of the heat. The

animal and human body becomes accustomed to no corrosive substance through increasing dosage. A certain dose and concentration will always produce corrosion whether or not the organism had previously received smaller doses."

We are very well satisfied with the results of the treatment detailed. Self-evidently, complications, which however are rare, would receive the proper attention, also the (not very common) cases where local affections demand local treatment. Affections of the scalp and loss of hair are treated with the following pomade: White precipitate, 3i; corrosive sublimate, grs. 3; vaseline and lanolin, aa ʒiiss; oil of rose, 5 drops, after the scalp has been thoroughly cleansed with a solution of bicarbonate of soda, which at the same time acts favorably upon the pityriasis capitis (scaling) sometimes complicating the trouble. No mercury is given during the intervals of freedom from symptoms, with this reservation, however, that should no relapse occur (a truly rare, but yet an event which may happen), three "courses of treatment," at least, should be gone through. As it will take up too much space we will not go into the treatment of the later so-called tertiary stages.

Considering what has been said above, we perceive that the inunction method is very good where the patient's circumstances permit its use; likewise the injections of soluble mercurial salts, especially in the presence of intestinal disorder; that, on the other hand, where the digestive organs are normal, the internal treatment is far to be preferred to inunctions as used in private practice. Our experience shows that a properly directed internal treatment is of equal value with properly used inunctions or injections with soluble mercurial preparations, and is of far greater value than the to us always objectionable injections with insoluble mercurial preparations.

THE many former students of the Charleston Medical College will learn with regret of the death of Dr. R. A. Kinloch, which occurred December 23d. Dr. Kinloch was a gentleman of the highest character, an excellent teacher and for years one of the most prominent of Southern surgeons.

# THE ASEPTIC CLOSURE OF LONG STANDING SINUSES HAVING THEIR ORIGIN IN TUBERCULAR JOINTS.\*

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By H. AUGUSTUS WILSON, M. D.,

Professor of General and Orthopedic Surgery in the Philadelphia Polyclinic and College for Graduates in Medicine; Clinical Professor of Orthopedic Surgery in the Woman's Medical College of Pennsylvania;  
Clinical Lecturer on Orthopedic Surgery in the Jefferson Medical College of Philadelphia.

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Recognizing the very extensive character of this subject, I have avoided elaborate details and arranged the paper more in the form of summary based upon modern aseptic practice, so that it should not occupy more time than is allowed for reading of papers. The class of cases that it is the purpose of this paper to discuss embraces a very large range of chronic runners from one hospital to another. They are usually designated as incurable or hopeless, and, as a consequence, are subjected to the so-called palliative or expectant plan of treatment, attention being largely confined to medication.

It occasionally happens that spontaneous resolution and closure of sinuses or fistulæ takes place, but this is the exception, the rule being that they continue patulous for a long time, often during the entire life of the patient. The well-recognized and thoroughly established fact that so-called cold abscesses frequently undergo absorption when unopened would seem to indicate the advisability of favoring such absorption by a closure of the openings that may have occurred from over accumulation.

The causes of these sinuses may be sought in a tubercular deposit in a bone or joint, or in the soft structures that surround a joint, which has formed a cold abscess, caseation and decomposition taking place, rupture follows. Part of the contents of the sac escapes and a sinus remains for a long period of years to act the part of a sewer-pipe.

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\* Read before the Philadelphia Academy of Surgery November 2, 1891. Reprint.

When rupture does not take place spontaneously it is apt to be induced by the evacuation of a cold abscess by an aspirator, for in this procedure it rarely occurs that the entire deposit is removed because it is not of the nature of a fluid. In the closure of the skin-wound made by the aspirator, the cicatrix is only superficial, and the subsequent spontaneous rupture is therefore facilitated at the site of puncture.

Likewise after incision, when the contents of the sac are thoroughly removed, the too long continued use of the drainage tube, or in some instances its use at all produces a sinus by the separation of tissues that would otherwise granulate. This sinus has not only no tendency to close, but the oft-repeated injections for the purpose of rendering the parts aseptic interferes with any granulation process that may have been commenced. In these ways sinuses are formed which persist, although often subjected to prolonged medication because of the supposed danger to the patient of any radical attempt at closure.

The teaching of Gross is still observed. "When the fistula has been of long standing, and has acted all along as a drain upon the system, serving perhaps to counteract some other affection, such as phthisis, or a tendency to apoplexy, no operation should be practiced, since it could hardly fail to provoke mischief; in fact, serious organic disease of any kind is a contraindication to an operation. The only exception to this is where the fistula is a cause of excessive local distress, completely depriving the patient of sleep, appetite and comfort. Under such circumstances the surgeon could hardly refuse his aid, but before doing this, he would be sure to open a new course of counter-irritation, in the form of an issue or seton, in some other or more eligible portion of the body, thus establishing a drain at least equal to that which he is about to suppress as a means of temporary mitigation."

In marked contrast is the modern teaching, for since the above was written in 1872, the adoption of aseptic methods has made it possible to reverse entirely the plan of procedure.

It is often best to consider a tubercular focus to be a malignant growth tending to increased destruction if undisturbed. While it is not malignant *per se* in the sense of malignant tumors tending

to the death of the patient, radical measures will more frequently and successfully be resorted to if this view is kept in mind in preference to its harmless character.

The freedom from disastrous results, in fact, the satisfactory recoveries obtained in excisions of tubercular hip disease, knee-joint involvements, and even when vertebræ are attacked, all tend to urge the adoption of this plan of procedure in the early stages of the disease, to limit the extent of the excision to the minimum.

Excision is not confined to early stages, but is as well adapted to conditions where the necrosis is very extensive and is a procedure now well established, but it not infrequently happens that a sinus follows which could have been avoided by recourse to methods to be alluded to later.

The vicious character of the infected parts tends to their non-union, and every means that can safely be resorted to for the complete closure of long-standing sinuses should be resorted to.

The great difficulty that is experienced of tracing a sinus after the parts have been laid open may be met in two ways. Prior to opening the sinus a probe may be introduced to the furthest part and allowed to remain as a guide.

The injection into the sinus and cavities in connection therewith of some coloring matter which will be innocuous, and at the same time so stain the lining membrane that its discernment and quick removal may be facilitated. I have found that a solution of pyoktanin meets the indications efficiently, for it possesses germicidal properties, and the greatest objection to its more general use is here its highest recommendation, for its purple color stains the tissues with which it comes in contact, thereby clearly indicating the tissues that it is desirable to remove. The object to be sought is the entire removal by clean incision of all of the stained tissue or lining membrane of the sinuses, and when the site of the original tubercular deposit is reached to excise it completely.

The laceration of tissues by tearing as a result of the use of an ecraseur or dry dissector or handle of a knife tends to sloughing,

and the necessity of providing an outlet by drainage tube, the avoidance of which is of considerable importance.

The infection of freshly incised tissue by the bacillus tuberculosis may be avoided by the free use of irrigation of sterilized water or solution 1 to 2,000 bichloride of mercury during the progress of the operation and the efficient use of iodoform before closure.

It not infrequently happens that a suspected bone origin to a sinus is found upon laying open the parts not to exist, but that the tubercular deposit is confined to soft structures and its ready removal easily accomplished.

In cases where a bone is found to be involved, the removal of the necrosed or diseased part should be done by a chisel, to the end that only normal tissue be allowed to remain. The process of superficially scraping is inadequate for the entire removal of the diseased tissues, and by its laceration does not conduce to healthy cicatrization.

If one or more contiguous bones are partially involved, the entire removal of such bones or of the joints is not essential, but only of such parts as are involved. To let the sinuses alone, or to continue the expectant plan of treatment, means a continuance of the annoyance of dribbling pus, positive discomfort, and a constant menace to the general health with but slight tendency towards recovery.

The constitutional disturbance depends more largely upon the exudation from the lining membrane of the sinus than from the tubercular deposit, as evidenced by the frequent freedom from constitutional disturbance in cases of unopened cold abscesses, and by the very great improvement in the general health following the successful closure of those sinuses which have existed for a long period.

The simple injection plan of treatment is found usually to be inefficient because of the mechanical difficulty of covering the entire surface of a sac by any material thrown in through a single opening, without recourse to hyperdistension. The danger of internal rupture of the sac at some weak and inaccessible point by hyperdistension is very great, and when this does take place not only

the material injected is thrown outside of the sac, but a new field of absorbent vessels is exposed to infection of bacilli.

A vent hole or counter-opening at the opposite side or furthest end of the sac or sinus avoids the danger of rupture and acts like a check valve, enabling the operator to command the quantity of material injected as well as the force of the flow.

Sinuses of great length may be closed by stages where the discharge is considerable by substituting an opening nearer the focus, thereby diminishing the constitutional effect of exudation from the greater surface and the portion between the openings completely closed. In turn this may often be still further shortened, until finally a complete closure is accomplished.

The danger of stitch wound abscess and the unsightly transverse cicatrices, which is very considerable in these cases, may best be avoided by having the sutures embrace only subcutaneous tissues, bringing the needle out through the edge of the incision and not through the skin. By this means deeper union is induced and the possibility of any gaping of the skin is avoided by the use of collodion-saturated gauze covering the incision.

Iodoform is pre-eminently a germicide for bacillus tuberculosis, and it is of great value in making it possible to seal the wound. The form most satisfactory for use in these cases being a 10 per cent. emulsion in freshly-boiled olive oil. The dry powder may be used, but its even distribution is difficult to accomplish and the crevices are not reached. The ethereal solution has been found objectionable, on the account of its too rapid absorption and the danger of iodoform intoxication.

The resort to packing with lint or other substance for the purpose of keeping the skin wound open and to induce granulation from the bottom, as well as the use of any kind of drainage, is generally unnecessary and often positively harmful, in favoring a continuance of the sinus.

If the parts are cleanly incised and maintained in close approximation, primary union may be expected throughout, and, if only healthy tissue be allowed to remain, drainage need not be employed. Occasionally it may be deemed expedient to use drainage for the first twenty-four hours, in cases where the pus con-



tinues to flow from inaccessible points, but its continued use is disadvantageous.

The procedures to be adopted may best be considered if the conditions are grouped as follows:

1. Those sinuses in connection with accessible joints where the tubercular deposit can be safely removed.
2. In similar positions, but where its removal cannot be safely accomplished.
3. Sinuses from inaccessible deposits.

Under the first heading, sinuses in connection with accessible joints, where the tubercular deposit can be safely removed, the modern plan of procedure is self-evident. Under strict asepsis, or chemical anti-sepsis, the focus should be removed in its entirety, leaving only healthy tissue behind. The cavity of the sinus denuded of its lining membrane by clean incision, in preference to tearing or scraping, and the entire cavity of the sinus and of the site of the former deposit rendered aseptic by thorough washing with peroxide of hydrogen, followed by irrigation of 1 to 2,000 bichloride of mercury, and, finally, the entire surface covered with iodoform emulsion. The parts are then to be brought into coaptation by subcutaneous sutures; iodoform dusted over incision; collodion gauze; finally, hermetically sealing the wound. Gentle but firm pressure with aseptic gauze and bandages complete the dressings.

II. Where the sinuses are in connection with accessible joints, where the removal of the tubercular deposit cannot be safely accomplished.

In these cases, as, for example, in hip disease, when the ilium has become denuded or involved, or in the lumbar vertebræ, it has been found judicious surgery to cut away all that could safely be removed, washing the parts as thoroughly as though the entire removal had been accomplished, as referred to under the first heading, and sealing the wound as described.

It will be expected that new cold abscesses will form from the unremoved unhealthy tissue, necessitating reopening, and the probability of this should be placed before the patient, so that at the very first indication of the necessity, the former procedure

should be repeated. The relief afforded by a cessation of the annoyances of the sinuses will more than compensate for the possibility of repeating the operation, nor is it certain that repetition will really be necessary.

III. Where the sinuses have their origin in inaccessible deposits—for example, when the bodies of the dorsal vertebræ are involved—it is often clearly impossible to lay open the sinus or reach the site of deposit, and recourse must, therefore, be had to other but less satisfactory means.

In most of these cases, the sinus only can be considered, and remedial measures must be confined to injections to render the parts thoroughly aseptic. A counter-opening, when practicable, greatly facilitates the accomplishment of the desired end—in fact, is often really indispensable. The closure of the sinus may be facilitated by excising as much of the outlet as possible, so as to procure union to a greater depth than by simply closing the skin opening. Both openings being closed, pressure is to be relied upon to close the sac. It is possible that in the attempt to eradicate the bacilli and effects from the sinus that the injected germicide may reach the site of the deposit, and act directly upon the focus, in which case the permanent benefit will be great.

In the cases upon which I have thus operated I have had no re-opening, or constitutional or other disturbances follow, but the time that has elapsed since the operations were performed is entirely too short to afford any indication of the permanence of the results obtained.

To have closed and kept closed for a year a sinus of the hip-joint of twenty-three years' standing is enough encouragement for a continuance of the method. To have removed a drainage tube from a knee that had been in constant use for eighteen months, the sinus having been daily subjected to washing, and new external dressings employed to catch the pus that should not have been allowed to continue to flow, and to have closed the sinus and have it remain healthy for nearly six months, is also encouraging.

It is my purpose to detail the results in these cases when sufficient time has elapsed to warrant the statement that they are permanently benefited. The full purpose of this paper will have been met if it assists in any way in the judicious treatment of a most troublesome class of cases.

1611 Spruce Street.

## Society Reports.

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### THE CLINICAL SOCIETY OF MARYLAND.

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259TH REGULAR MEETING, BALTIMORE, DECEMBER 18, 1891.

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The society was called to order by the President, DR. ROBERT JOHNSON.

DR. C. W. MITCHELL read a paper entitled,  
AFTER INFLAMMATION—WHAT ?

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DR. WM. B. CANFIELD read a paper on

DUST AS A CAUSATIVE FACTOR IN PULMONARY DISEASE.

The various kinds of dust may be divided into animal, mineral and vegetable. Opinions differ as to which kinds are most dangerous when inhaled. That which is generated in brush factories is animal and very harmful. Makers of hats, especially felt hats, suffer much from the dust evolved. The vegetable dust that does the greatest and most lasting injury to the lungs is that generated in tobacco factories. This dust has not only a mechanical action, but has also poisonous effects.

It is in connection with the inhalation of mineral in it that the greatest amount of scientific investigation has been made, especially in relation to the diseases called the consumption of grinders, miners, potters, etc. Anthracosis, silicosis, siderosis, chalicosis, tabacosis and other kindred names have been suggested to describe a similar condition produced by various kinds of dust. Zenker has handed down the word "pneumonoxoniosis" to cover all these conditions. The history of these cases is very much alike. They begin with simple bronchitis which gradually becomes chronic. They are usually non-tuberculous, at least at the beginning tuberculosis complication is only an accident.

Where one is exposed to an atmosphere of dust the contact of this dust with the sensitive nasal and laryngeal mucous membrane sets up coughing and sneezing, and much of the dust is expelled, and for a time no harm results; but a continued exposure to this dust causes a congestion of the mucous membrane of the nose and breathing passages and in time an inflammation of the whole tract; the ciliated epithelium loses its power and dust finds its way to the ultimate ends of the lung tubules. When the individual is asleep or absent from this irritation, the ciliated epithelium gets rid of a large part of this foreign substance, and the wandering cells may close around some of this dust and try to carry it off or render it harmless by burying it in a lymphatic gland. Much, however, finds its way either through the epithelium or between the cells into the submucous layer, getting into contact with the connective tissue of the alveoli, and by irritation causing a hypertrophy of this tissue, and a condition resembling chronic interstitial pneumonia or fibroid phthisis. The general opinion seems to be that the fibroid condition seems to oppose a direct barrier to the growth and multiplication of the bacillus tuberculosis, and in large tracts of lung tissue converted into this material often not a bacillus could be detected. In one of the author's cases bacilli were found in abundance, and yet two year afterward the man reported himself as entirely well.

The color of the expectoration is a prominent sign in these cases. In one case of the author, a stoker, the expectoration still continues absolutely black at times, and always tinged, although it is almost two years since he gave up his occupation. Examination of this sputum under the microscope showed it to contain in abundance carrier cells which in all cases contained pigment and in some instances the black crystalline coal could be recognized within these cells. This pigment and foreign material has a tendency to collect at the apices of the lungs, and is only present at the bases when the dust inhaled is excessive in amount and exposure prolonged.

In diagnosis, physical signs do not yield as much as the microscope. By the microscope we see the cells containing the

dust. In the author's cases (four) râles were heard on auscultation, but nothing marked was obtained on percussion.

The prognosis is good if the man has not worked too long at the occupation.

The treatment is to take the patient from his dangerous occupation, when improvement begins at once. Owners of large factories are adopting stringent prophylactic measures in order that they may not lose so many good workmen. The best methods are : 1. To prevent the formation or escape of dust by using wet grinding or by grinding in closed vessels. This is not always practicable. 2. To prevent inhalation of dust by wearing respirators, etc. But these are uncomfortable, and the men remove them at every opportunity. 3. The removal of dust as fast as it is produced by using fans and air shafts. This is by far the best plan.

Still further the following rules should be enforced : 1. Workmen should change their outer clothing after work. 2. They should keep their faces and hands as clean as their work will allow. 3. They should never be allowed to eat in the work-room.

DR. RANDOLPH WINSLOW related

#### A CASE OF ELEPHANTIASIS SCROTI.

J. C., colored, aged 44 years, was admitted to the University Hospital, September 7, 1891, on account of enlargement of the scrotum and perineum. His father died of meningitis, and his mother of phthisis. Patient is one of seven children, six of whom died of phthisis. He had measles in childhood, typhoid fever at twenty-one and gonorrhœa about eight years ago. The present disease began about three years ago, with slight thickening of the tissues of the scrotum, penis and perineum, the infiltration first showing itself in the skin of the scrotum and increasing slowly until at the time of his admission, the scrotum was enormously enlarged and reached one-third of the distance to the knee. There were a number of suppurating sinuses and superficial abscesses in the scrotum and perineum. There was some pain. The tissues of the scrotum were brawny and very

little impression could be made on them by pressure. The perineum was composed of similar tissue and was enormously hypertrophied. The skin of the penis was also thickened, but retained its suppleness and the prepuce could easily be retracted. The patient said that his virile powers were unimpaired. He was a sailor, but had never been much beyond the coast of this country and had never resided in a tropical country. Several efforts to detect the *filaria sanguinis hominis* were unsuccessful.

The sinuses were incised, and a long incision made in the perineum to relieve tension and allow the lymph and blood vessels to empty themselves. He was placed upon iodide of potassium, as syphilis could not be excluded. He did not improve, and excision of the scrotum and perineal hypertrophy was performed October 1st. The skin and subcutaneous tissues were very dense and thick and freely supplied with blood vessels. The testicles were carefully dissected out and were uninjured. The gap in the perineum was closed with sutures, but there was not sufficient tissue to cover the testicles, hence lateral incisions were made in the contiguous skin and strips of skin dissected up and brought over so as to form a new scrotum. The tension was great and the stitches cut out allowing the flaps to separate considerably. Healing was effected under about five dressings, and he was discharged well on November 8, relieved of pain and discomfort, and ready again to resume his ordinary avocations.

W. T. WATSON, M. D.,

1603 N. Broadway, Baltimore.

Secretary.

WE learn that Mr. William Rose, of London, has now operated four times for tic douloureux by removing the Gasserian ganglion. Patients are said to have been benefited.

THE next meeting of the Southern Surgical and Gynecological Association will be held in Louisville, Ky., November next. President, Dr. J. McFadden Gaston, Atlanta, Ga.

IT is stated in the secular press that the bacillus of influenza has at last been discovered by Dr. Pfeiffer, the son-in-law of Dr. Koch. The bacillus is said to be the smallest yet observed.

## Correspondence.

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### OUR NEW YORK LETTERS.

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NEW YORK, December 14th, 1891.

#### UTERINE DRAINAGE FOR CHRONIC METRITIS AND ENDOMETRITIS.

This was the subject discussed at the last meeting of the Academy, where Prof. Wm. M. Polk read a paper in which he advocated a plan which had proved very successful in his hands. He stated that he believed that the timidity with which most writers regarded any interference with the interior of the uterus was misplaced. His experience with vaginal hysterectomy had taught him that if scrupulous cleanliness were observed, the cavity of the uterus could be entered with impunity. He had therefore been led to try the effect of packing with gauze in metritis and endometritis with and without salpingitis. In cases of puerperal or gonorrhœal origin this treatment was always pursued; it had also been successful in a number due to flexions and other causes. In hemorrhagic cases curetting was first employed, followed by packing. The common dictum to avoid invading the uterus when the appendages or surrounding tissues were inflamed had not been respected by him, as he had resorted to packing in such cases with the hope of preventing the extension of disease or of modifying the conditions already existing. Rest, laxatives, hot douches and glycerine tampons were first tried; then, if the disease persisted drainage was resorted to. If the procedure was properly conducted, he did not regard it as dangerous; if not, however, it might become so. He had treated forty cases, and the usual effect had been a rise of temperature during the first twenty-four or forty-eight hours, to be followed by a fall which was permanent.

His mode of operating was as follows: The interior of the

uterus was washed out with a solution of bichloride 1 to 5,000. In puerperal cases the os was usually sufficiently patulous. In other cases it would have to be dilated. In such instances the vulva, vagina and cervical canal were cleansed as for a hysterectomy. Dilators were then introduced into the cervical canal until it became sufficiently enlarged to admit a cervical speculum. As this was a rather painful procedure an anæsthetic was usually required. After the uterine cavity had been irrigated, curetting was done if necessary. While the preceding steps were being taken, strips of sterilized cheese cloth, three feet long and three-quarters of an inch wide should have been soaking in a bichloride solution of 1 to 500. These should now be removed and thrown into hot water. From this they were taken and transferred to the cavity of the uterus which was completely filled. This was accomplished by means of a screw which he had devised, which could be more readily disengaged from the meshes of the gauze than any other instrument. The loose ends were brought out through the os, and after the speculum had been removed, were curled up against the cervix. A plug of the gauze was then placed in the vagina. If much pain followed the operation, hot fomentations to the abdomen usually relieved it. At the end of six or seven days the plug should be removed, if uterine contractions had not already expelled it, and the patient might be allowed to rise. The longest duration recorded by him was two weeks. The amount of depletion from this plan of treatment was apparent in the profuse discharge observed on the second, third and fourth days.

Dr. W. T. Lusk said that he had had no experience with the plan of treatment suggested, but thought the principle was good, as no inflamed mucous membrane could recover while bathed in morbid secretions. He had employed similar measures in puerperal septic conditions, when the patient seemed moribund, sometimes with marvellous results. He believed that many tube inflammations originated in the cervix.

Dr. C. C. Lee stated that uterine drainage had been employed by him in a number of cases, but his method had been different



from that pursued by Dr. Polk. He never used bichloride solutions within the uterus, as he had seen poisonous symptoms produced by this procedure. He used simple hot boiled water instead. His plan consisted in dilating the cervix with Palmer's or Dudley's dilators, then curetting and irrigating, and afterwards stitching into position one of Cleveland's perforated glass drainage tubes. This was kept in place for ten days, and was then replaced by a stem pessary, which was worn for a considerable period, the patient returning occasionally for observation.

Dr. W. G. Wylie thought that the introduction of the cervical speculum was impracticable, when there was stenosis of the os, and might result in splitting of the uterus.

Dr. Edebohls had seen a few cases in which diseased tubes had seemed to drain naturally through the uterus; in such cases he believed that packing would be very useful.

Dr. Thomas Addis Emmett said that he had formerly tried several methods of uterine drainage, in cases of subinvolution and endometritis, and had met with some success. The cures had not been permanent, however, and he abandoned the treatment. He had resorted to it again during the past two years, when distended tubes drained naturally into the uterus. As for metritis, he hardly knew what the term meant, as there was no true mucous membrane above the internal os. A new growth, or some condition due to injury or to parturition might demand treatment of the interior of the uterus. Where there was nothing but hypersecretion, the real disease must be looked for outside of the uterus. He believed, however, that drainage would prove useful for the treatment of diseased tubes.

The plan of treatment suggested by Dr. Polk seemed to meet with general approbation, and most of the speakers expressed their intention of giving it a trial.

#### THE TREATMENT OF BUBOES.

A rather novel method of treatment of this troublesome condition was discussed at the last meeting of the Surgical Society. Dr. McBurney read a paper. He said that the old treatment was to paint with iodine; if suppuration seemed inevitable poul-

ting was resorted to, and when fluctuation was detected an incision was made. Five years ago he had adopted radical excision as a general rule of treatment. Now he divided his cases into three classes; those in which the glands were tender and hard without any sign of septic infection; those in which there were signs of gland deterioration, tenderness, redness, and softening; those in which the glands were completely broken down. Cases of the first class were treated by the application of cold. Those of the second were suitable for excision, all the glands being removed, and those portions of the skin which were badly involved in the inflammatory process. This treatment succeeded in proportion to the freedom of the glands from softening. It was in the third class of cases, in many of which excision was hopeless, that he had been led to adopt injections of iodoform and vaseline, as advised by Pontain. He had treated twenty cases. The method pursued was to make a small opening, through which the fluid was expressed. A small spoon was then introduced and dividing septa and connective tissue bands broken down. The sac was then overdistended six to twelve times with a bichloride solution 1 to 1000. Then by means of a syringe a mixture of iodoform and vaseline, a drachm to the ounce, which had been heated to fluidity, was injected. The application of a cold gauze compress caused the vaseline to harden in a few minutes. In two cases treated by him complete failure had resulted; in eight a partial success was secured, and in the remaining ten the success was complete after the first or second injection. Five had recovered before the fourteenth day, and the average duration of all was nineteen days.

Dr. Briddon said that he had wounded the saphena vein in operating for the excision of buboes, and was obliged to ligate it.

Dr. Pilcher, of Brooklyn, remarked that up to this time he had regarded the treatment by vaseline injection with scepticism. It seemed to him now that it might, perhaps, be best to let buboes mature, and then treat them in this way rather than to employ excision. Gangrene of the scrotum had followed one of his operations, probably from interference with innervation.

Dr. L. A. Stimson believed that the danger of wounding the large veins could be avoided if the operator made the discovery of their location the first step in the operation after the preliminary incision.

Dr. Groger said that since he had begun to treat chancroids by powdering the surface thickly with salicylic acid, buboes had seldom occurred.

Dr. Abbe had found that suppuration usually resulted after operation for excision. He had, therefore, abandoned suturing and packed the wound with gauze for thirty-six hours, when the granulating surfaces were allowed to fall together to heal by secondary adhesion.

In closing the discussion Dr. McBurney said that with the improved methods of wound treatment sutures could be used with very satisfactory results. Fifty per cent. of his cases healed by first intention. He thought that it was unnecessary to wait until a bubo became a pus sac before resorting to the vaseline injections.

He exhibited a case in which treatment had been begun four weeks before. It had been a very bad case, a tense sac of pus six inches across having existed. One injection only was employed. The place was now almost entirely healed, with the exception of a small sinus perfectly sweet and free from pus, but from which vaseline could be expressed.

#### TREATMENT OF PULMONARY ŒDEMA.

An interesting discussion on this subject took place at the last meeting of the County Society. Dr. A. A. Smith read a paper. He stated that the cause of many cases of acute Œdema of the lungs was not always apparent. Interference with the nervous supply was often the only satisfactory explanation, this being perhaps brought about by the poisonous effect of uræmia on the ganglionic system, causing it to lose its hold on the pulmonary blood vessels. Although a sudden attack of Œdema of the lungs might be the first suggestion of kidney disease, such cases were rare, compared with those in which the condition was of gradual onset. Even when there was marked diminution in the

quantity of urine excreted, pulmonary œdema did not always appear until the kidney disease had existed long enough to cause changes in the blood and in the walls of the vessels. A remarkable instance was that in which a kidney was removed from a patient in Bellevue Hospital, and no urine was excreted for eleven days, when the patient died. No pulmonary œdema appeared in this case, and yet the autopsy revealed that the woman's only kidney had been removed.

He had found the treatment by dry cupping unsatisfactory, and had therefore resorted to other measures. His custom was to administer strychnine and atropia hypodermically and nitroglycerine by the mouth. Atropia was a cardiac and respiratory stimulant; strychnine was also, and a vaso-motor stimulant as well. Nitroglycerine distributed the blood through the arterial system. He gave it in one one-hundredth of a grain dose every two hours. One-fiftieth of a grain of strychnine and one one-hundredth of a grain of atropia might be given every two hours for two doses, and afterwards every four hours. If renal disease were the cause of œdema, morphine was of the utmost value. If cyanosis were pronounced, oxygen was useful, care being taken not to put the tube too near the mouth.

Dr. Roosevelt said that he had not found the treatment by dry cupping entirely unsatisfactory. He had also used strychnine, in alcoholic cases to whom he had given one-thirtieth of a grain every half hour for four doses, the patient being watched carefully in the meantime for poisonous symptoms.

Dr. Kinnicutt had used nitroglycerine in one-fiftieth of a grain doses or smaller, being guided by the feelings of the patient in regard to flushing of the face, etc. His custom was to give the remedy up to the point of producing subjective symptoms, and he thought that it might be given every twenty minutes indefinitely or until the pulse grew soft, as its effects were so evanescent.

Dr. Andrew H. Smith said that sodium nitrate in two grain doses produced an effect similar to that of nitroglycerine, and much more lasting. He believed in the efficacy of opium in uræmic cases. Digitalis was positively contraindicated; its

effect was to empty the arteries into the veins, while our object was to empty the veins into the arteries.

#### TREATMENT OF PERITYPHLITIC ABSCESS.

The so-called simple incision in perityphlitic abscess was also discussed at the same meeting as the preceding subject. Dr. McBurney introduced the subject. He said that so long as it was considered that the abscess originated in the connective tissue outside the peritoneum it had been thought good treatment to wait until pointing occurred, before making any incision. Now that the part played by the appendix vermiformis was known, and the fact that pus did not appear outside the peritoneum until a late stage of the disease, other treatment had been instituted. It was not best to wait until the abscess reached the surface; the sac should be searched for and then opened carefully with a small incision to prevent flooding of the peritoneum. The position occupied by the appendix was uncertain, and the abscess might point in any direction. Most surgeons therefore operated early.

Dr. Gerster said that a case had come under his observation in which an aspirating needle had been used to detect pus. On this a grooved director was passed, and a free incision made. The result proved that the intestine had been incised, and a fæcal fistula resulted.

Dr. L. A. Stimson remarked that while the surgeon was waiting for the proper time to make the simple incision, the patient might die, or grow so bad as to render the operation useless.

There is some difference of opinion among the surgeons here regarding the propriety of an exploratory puncture by a fine needle to determine the existence of pus in these cases of perityphlitis. Dr. McBurney has stated that he has observed a case in which such a puncture would have penetrated the intestine four times. The case referred to by Dr. Gerster is also suggestive. On the other hand, there are some who, arguing from practical experience, say that they have used the needle in many cases and have never seen a bad result.

WM. L. RUSSELL.

NEW YORK, January 12, 1892.

A most interesting and important paper was read at the last meeting of the Academy by Dr. Virgil P. Gibney. The subject was

TUBERCULAR OSTEITIS OF THE KNEE.

The object of the paper, as stated by the reader, was not to present anything new, but rather to illustrate the methods of treatment at present pursued, and what results it was possible to secure. A large number of cases were exhibited whose movable joints and straight limbs spoke more forcibly than anything that could be said by the speaker.

The occasion was honored by the presence of the veteran orthopedic surgeon, Dr. L. A. Sayre. Dr. Sayre is a victim of chronic rheumatism or gout, and is now seldom seen at public meetings. His firm voice and vigorous manner of speaking, however, showed few signs of the weight of years which he carries, and there could be no doubt about his active interest in recent developments in his specialty. He said that when he compared the present condition of orthopedic surgery with that which existed fifty years ago it made him feel that he had not lived in vain. Fifty-one years ago, when he was a medical student, he ignorantly opened an abscess due to disease of the knee-joint. He was sharply taken to task by his preceptor, and the death of his patient was confidently predicted. Much to his surprise and satisfaction recovery and a useful joint followed, and his faith in professional wisdom was permanently shaken. He believed that the good result obtained then, and in many other cases afterwards treated by him, was due to the fact that in using balsam of Peru freely he had practiced antiseptic surgery without knowing it.

Dr. Gibney drew attention to the fact that the history of cases coming to him and to other orthopedic surgeons showed that many practitioners were not sufficiently careful in examining the joints in the early stage of the disease. The child saved the joint by limping and stiffness for some time before the real difficulty was suspected. Joints should be examined bare of cloth-

ing, and corresponding joints on both sides of the body should be compared. Some modification or limitation in function would then be discovered, or possibly points of tenderness, a change in contour, atrophy of the calf muscles, or increase in the knee measurement, or in the heat of one knee, would be noticed. The failure to make such an examination resulted in neglect of treatment and the advance of the disease to the stage of deformity or of abscesses. The plan of treatment preferred by him was that by immobilization until the symptoms had subsided. He quoted statistics of a large number of cases which had been treated at the Hospital for Ruptured and Crippled, which seemed to prove that the best results were obtained from this plan. Relapses had been very infrequent, and only twelve per cent. of the cases had required support during the rest of life. He was opposed to excision during early life, and exhibited two cases in which marked deformity and shortening had resulted from the operation. Several varieties of apparatus were shown, among which the Thomas splint was the type of that used by him. It consisted of a posterior leather trough, which was fastened on by a bandage.

Dr. Sayre believed in the method of treatment advocated, but would add some means of producing traction to the Thomas splint. This was necessary to protect the joint from the persistent traumatism produced by the reflex muscular contraction by which nature sought to immobilize the joint.

Dr. McBurney said that though apparatus might be necessary in the early stages, the surgeon in the meantime watching the progress of the case, a large proportion reached a state which required the use of the knife and the saw. All sections should be made above and below the epiphyseal lines, as otherwise the growth of the limb was interfered with.

#### DIGITALIS IN PNEUMONIA.

The propriety of administering digitalis in pneumonia and in pulmonary oedema is a question that has attracted considerable attention ever since Dr. A. H. Smith published a paper on the subject, which was referred to in one of my letters several months

ago. Dr. Smith claimed that as the strain was on the right heart rather than on the left, the indication was to dilate the blood vessels and empty the veins into the arteries. The action of digitalis was to contract the vessels and to empty the arteries into the veins; it was, therefore, contraindicated. A number of observers have objected to Dr. Smith's sweeping denunciation of the remedy, on the ground that clinical experience was favorable to its use. Amongst those who make this claim is Dr. Jacobi. During the recent discussion on pulmonary œdema at the County Society, he stated that in the acute forms of the disease, where active interference was urgently demanded, he was accustomed to give from one to four doses of digitalis. Ten grains of the powder, or the same number of minims of a fluid extract, was the quantity at each dose. Cathartics, pilocarpine, hot packs, and hot-air baths were other measures which might be indicated in special cases. Caffeine was also a remedy of great value.

Dr. Mary Putnam Jacobi expressed a similar opinion in regard to digitalis. At the meeting of the section on Pædiatrics held last evening, she reported a very severe case of infantile pneumonia, in a child nineteen months old, in which there was consolidation of the lower portion of the left lung and of the middle portion of the right, with a pleuritic effusion on the left side. The temperature reached  $106^{\circ}$  and the pulse 150, with the respiration at 72. The treatment consisted in the administration of diffusible stimulants, with the employment of cold-packs, and the inhalation of oxygen. The child recovered, but eventually an operation for empyema was required, which resulted in a sinus which was a long time in closing. During the discussion drawn forth by the relation of this history, Dr. Koplik said that a portion of rib should be resected whenever an opening was made into the chest cavity for empyema. This facilitated drainage and encouraged the rapid closure of the cavity.

Dr. McBurney approved of Dr. Koplik's view, and added that if the resection was subperiosteal no permanent injury was inflicted.



## PERITYPHLITIS.

We have not yet heard the last of this subject. The question which seems to be most prominent at present is not: "Shall an operation be performed?" that seems to be settled, but "When is the proper time for its performance?" What is meant by "early," and what by "late?" These were the questions asked very pertinently by Dr. Jacobi at the last meeting of the County Society, when he narrated the histories of two cases illustrating the difficulty in deciding these points.

In replying to the questions, Dr. McBurney stated that most "early" operations were performed in the first four days, most "late" ones after the first ten days. The question was not one of time, however, but of the condition of the patient. It was not necessary to wait until pus formed. This should be anticipated. If the patient was regarded as seriously ill, and radical treatment of some kind was required, the operation offered the best prospects. Dr. McBurney discussed the subject still further at the last meeting of the section on Pædiatrics. He stated there that he had met physicians who claimed that appendicitis never killed, and there were a large number who believed that an operation was indicated only as a last resort. Formerly, it rested with the surgeons to show proof that the operation was a real and comparatively safe remedy; now, the position had changed, and the burden of proof rested with the physicians. In judging of the time for operating the constitutional symptoms were not as safe an indication as the local conditions. A chill did not occur, and the temperature varied from normal to  $103.5^{\circ}$ . The pulse, too, might not indicate the gravity of the case. Much more reliance was to be placed on the local signs. Increasing pain, with more and more marked tenderness, more easily detected at each examination, were signs not to be disregarded. The most important point to be gained at present, was an acknowledgment that there was a remedy. If a curative remedy, such as quinine in malaria, or mercury in syphilis, had been discovered, it should be accepted. In the experience of all the New York hospitals, the results from operation for appendicitis were so

superior to those obtained by any other plan of treatment, as to render comparison ridiculous. The mortality among those treated by other plans of treatment was over twenty or twenty-five per cent., not to speak of the cases in which a diagnosis was not made, of which, judging from his experience, there must be a large number. The mortality after operation was very much less than ten per cent. He had only seen one death. He had been unable to formulate a set of symptoms which would form a guide to others in determining the time to operate. He did not regard this as extremely important. Every physician was able to decide when his patient was so sick as to demand radical treatment. He showed this by making repeated visits or calling a consultation. This was the time to operate. Also, whenever an exact diagnosis could be clearly made, the remedy should be applied. Dr. L. A. Stimson remarked that if an operation was to be successful, it must be done early. The mortality after operations was only one or two per cent. In his own experience, and among his friends with whose work he was familiar, he had not known of a single death, except when general peritonitis was present. Whenever the diagnosis was made, the operation should be performed.

## DIPHTHERIA.

At the last meeting of the section on Pædiatrics, Dr. J. Lewis Smith gave a short report of the year's contribution to the knowledge of diphtheria. He made the extraordinary and startling statement that the mortality of this disease was 140 to 100,000 of the population in America, while in England it was 49 0 100,000. He said that continued experience with the following antiseptic vapor seemed to indicate that it exercised some influence in preventing the spread of the disease. It enabled physicians to visit other patients with impunity. It was even claimed by some that its use prevented diphtheritic paralysis. The formula was as follows:

R.	Acid. carbolic,	
	Ol. eucalypti,	aa ʒi.
	Spt. terebinthinæ,	ʒviii.

M. Sig.—Two tablespoonfuls in a quart of water to be kept simmering on a stove in the sick room.

The chloride of iron in some form, which had been first used in diphtheria in 1859, was still in general use in France, Germany, Great Britain and America. Benzoate of sodium was also used in France in large doses. Salicylic acid and resorcin were used by some, but it had been shown that their germicidal power was very faint. He thought that prompt prophylactic measures and local treatments were the only measures on which any great reliance could be placed. A long list of local remedies had been introduced during the past year, most of them being valueless. The use of peroxide of hydrogen had extended. It was scarcely inferior to bichloride of mercury as a germicide and was not poisonous nor irritating to the mucous membrane. It could be used as a spray pure, or for young children diluted with equal parts or twice the quantity of water. When used in the nose, it should be diluted three or four time. Acetic acid as a spray or gargle has been recommended by some. A new method of local treatment has been introduced by Dr. Seibert of this city. It consisted in the injection of peroxide of hydrogen into the deeper tissues of the part affected by means of a needle with several prongs attached to a hypodermic syringe.

#### LA GRIPPE.

The mysterious influenza (influence) is again at work among us. During the past two months it has helped to swell the death rate considerably, and has contributed largely to the mortality of other epidemic and systemic diseases. The same general symptoms have been noted as in former visitations, but the three varieties, noted elsewhere, have made themselves more apparent. In some cases nervous symptoms only are present, such as headache, pains in the back and limbs and neuralgia. Some of these cases are afebrile, the most pronounced symptoms being mental depression, sometimes with suicidal tendencies. The catarrhal form is that most commonly seen. In this the disease seems to manifest itself principally by an intense inflammation of the nasal passages, the pharynx and air passages. Several cases of the so-called gastric variety have also been observed here. In this there are, besides the general constitutional symptoms common to

all varieties, pronounced gastro-enteric symptoms, such as pain, vomiting and diarrhoea. In a recent paper read at the Clinical Society of London, the view was taken that influenza was an infectious nervous fever due to a special poison circulating in the blood and causing congestion of the medulla oblongata. The different varieties which had been noticed depended on the part of the bulb principally affected. Thus in the nervous form the thermolytic, cardiac and other centres were especially congested. In the catarrhal variety, the congestion was largely confined to the nervous mechanism formed by the nuclei of the fifth and the vago-accessory nerves, while in the gastric form the vomiting centre was congested and the shock was transmitted to the splanchnic nerves, which anastomosed with the pneumogastric in the coliac plexus. A similarity between the poison of influenza and that of syphilis was noticed, in that both showed a tendency to attack all parts of the nervous system after the acute symptoms had subsided. The poison of influenza surpassed that of syphilis in its virulence and rapidity of action.

The question of the contagiousness of influenza is still unsettled. The general opinion among observers seem to be that it is not contracted by one patient from another.

151 East 50th St.

WM. L. RUSSELL.

TREATMENT OF BRONCHO-PNEUMONIA IN CHILDREN.—Simon recommends the following prescription in the early stages of this condition:

℞. Acetate of ammonium, 7 grains.  
Tincture of aconite, 15 drops.  
Codeine, 2 grains.  
Simple syrup, ½ ounce.  
Water enough to make 3 ounces.

A teaspoonful of this may be given every hour until five or six doses are taken. At the beginning of an attack a mustard plaster or other form of counter irritation should be applied over the thorax, and after it has acted for one or two hours should be followed by an emollient poultice. It is also well to allow steam from boiling water to pass into the air of the sick-room.—*L'Union Medicale.*

## Editorial.

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### SPECIAL NOTICE.

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The office of THE JOURNAL will hereafter be with that of Dr. Hutchins, rooms 43 and 44 Old Capitol Building.

THE JOURNAL will be glad to have its friends, the doctors, call when in the city. Take the elevator, on Forsyth street side.

#### A CHANGE IN PAPER.

Owing to our having changed the style of paper, upon which THE JOURNAL is printed, from a rough finish, *thick* paper to a *thinner*, glossy paper, which gives a better typographical display, the impression may exist that we have reduced the number of reading pages or that advertisements have decreased. SUCH IS NOT THE CASE. We still give you the full (64) *sixty-four* pages of reading matter and the advertising pages have *not decreased*. *Subscription, \$2.00 per annum.*

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### THE OPEN DOOR FOR QUACKERY.

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Unfortunately there does exist among medical men a certain class that refuses to be governed by the rules of professional propriety. Each of these is a law unto himself, and pursues his dubious occupation as his own morbid taste may dictate.

Often we notice that, with a boldness and presumption born of ignorance and unexcelled in any other class of men, he announces in the public prints that he is prepared to treat successfully every ailment in the wide range of human infirmity, from

bee-sting to hydrocephalus, and from the indiscretions of ardent youth to the weaknesses of age.

Less often, with a rare and becoming modesty, he informs the public that his professional skill will be confined to the treatment of such medical and surgical commonplaces as cancer, or rupture, or catarrh, usually inserting the important and catchy promise, "no cure, no pay." Disease and death, sorrow and suffering would appear at least to be under absolute control. Even child-bearing woman, who has been laboring (no pun intended) for all these centuries under the primordial curse of bringing forth her young in sorrow, is now told with the pleasing and comforting assurance that her labors may be robbed of both discomfort and danger and be made as sweet as a dream of love in June.

Unfortunately, these apologies for physicians are far too numerous, but sadder still is the fact that there are many who repose a trustful confidence in the impudent statements and promises of these people, which they see in the papers. Along with these advertising frauds are to be classed also the patent medicine humbugs who detail to the public the universal curative properties of their worthless nostrums under high ministerial indorsement. Without conscience and without scruple this anomalous physician plays upon the fear and ignorance of his trusting patient and literally bleeds him for "all he is worth." That we are writing advisedly the following case will show: Not long since a young man, a newspaper reporter, came to our office for examination, with the history that he had been under the treatment of a rupture "specialist" for some time with no improvement in his condition. The rupture expert had clapped on a truss, of course, for which, with his treatment, he was making the modest charge of twenty-five dollars. On examination there was found a moderate degree of varicose enlargement of the spermatic veins of the left

side. Nothing more, but this had probably been made worse by the pressure of his truss. This mistake was made either through ignorance or the intent to deceive. In either case the man that made it should not be allowed to practice medicine.

The trade of quackery, we all know, will take root and flourish wherever a suitable locality can be found, and, *a priori*, the most suitable locality is that one which offers the least obstacles to the conduct of the business.

In Georgia, we are sorry to say, the conditions are most favorable for the quack doctor; he enjoys the absolute liberty of the State, and pursues his shady occupation, unawed by shame or fear. In any community one of these men is a surplus; in Atlanta there is an overwhelming superabundance. Their faces and their cards, with an impudence and effrontery that is characteristic, appear daily in the columns of the public press. It matters not how dense their ignorance their professional skill seems to know no limitations. One of these applied to us recently, in great haste and excitement, for a quick emetic to enable him to throw up a half-drachm of sulphate of zinc which he had taken by mistake! A medical contemporary, published in Atlanta, has already and truly announced, some weeks ago, that impostors are infesting the State, and that quackery is rampant in Georgia. The reason is to be found in the fact that Georgia makes no effort to keep them out. Here is a good opportunity for legislation. The State should exercise some discrimination as to what kind of persons shall practice physic within her limits. Instead of this, her doors are open wide, and he who desires may enter and practice his dangerous and shameless methods with none to molest or make afraid. If one wishes to run a dray, or keep a butcher-stall, or dispense peanuts and bananas on the street corners, he must get a license, but one—any one, that doesn't matter—can practice medicine for the asking. As

long as this condition exists, you may depend upon it, our State will be the refuge for all the quacks and charlatans that are being driven from other States. The majority of States, we believe, have taken this matter in hand, and by their Examining Boards, or Boards of Health, are forcing these medical frauds and impostors to seek their dishonest livelihood elsewhere. The cause is just, and will finally prevail—even in Georgia.

But, at present, the door for quackery stands open wide—the more's the pity.

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### THE INFLUENZA AGAIN.

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This winter witnesses the third annual appearance of the "Grippe" in this country. In the North it began about two months ago, and in a short time it had reached nearly every section of the Union. The arrival of the "Grippe" in this country after our people had enjoyed an immunity from the epidemic for a period of eleven years, was treated lightly at first, and people spoke of it with a careless unconcern that might have been used with reference to attacks of chicken-pox. But toward the end of its first season complications, principally pneumonia and an obstinate bronchitis, began to carry off a patient here and there, usually the debilitated and infirm, and it was realized then that the "Grippe" was not such an insignificant thing after all. Since that time it has claimed many victims.

The epidemic of one year ago was not so severe, and the present seems to be milder still. In fact, in Atlanta there have not been a great many cases of genuine influenza. To be sure, during the last two months there has been a sort of epidemic of colds, but certainly all of the cases which have received the lay or professional diagnosis of the "Grippe" were not really such.

But we wish to speak particularly of the treatment. In the three visits which the "Grippe" has made to us many have been



the treatments followed, and nearly every physician has pursued his favorite method, which he found to answer the purpose exceedingly well.

In the New York *Medical Journal*, January 9th, Dr. J. Harrison Mettler, of Chicago, outlines the course of treatment which he usually pursues, and as we have had a satisfactory experience with practically the same methods we give the following brief description:

In the first place, absolute mental and physical rest is all important. A hot bath should be taken at night before retiring, after which the patient should get in bed between heavy blankets. Patient should take eight or ten grains of quinine, and a pill containing extract of opium (gr.  $\frac{1}{4}$  to  $\frac{1}{2}$ ), camphor and ammonium carbonate (aa gr. ij). Instead of the latter pill we have usually used a ten-grain Dover's powder. A hot whiskey punch will be an advantage also. Thus pain is relieved, diaphoresis is established and sleep induced. In the morning the patient will feel much better. During this day he should remain in a warm room, and at intervals of two or three hours take some stimulus, as milk punch or brandy. If fever be present quinine should be given, two grains every three or four hours. If fever persists and shows a tendency to rise toward evening, phenacetine may be employed. For the nervous exhaustion often seen the author uses the hypophosphites, or a pill of arsenic, strychnine, quinine and the dried sulphate of iron. We have depended principally on the use of phenacetine, four grains about every three hours. At night the patient may repeat the process of the night before. Diet should be light and nutritious, with milk as the staple article of food.

In the ordinary cases as they present themselves the above represents, we believe, an excellent method of management. No mention is made in the article under consideration of the coughs which are sometimes troublesome. For these we know of nothing better than a mixture containing equal parts of syrup of wild cherry, paregoric and Wyeth's compound syrup of white pine.

## Selections.

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BLAUD'S PILL IN ANÆMIA.—“In his interesting articles on anæmia, Dr. Stephen Mackenzie discusses with some care and anxiety the proportions of alkali to be combined with sulphate of iron in Blaud's pill. Let me assure Dr. Mackenzie and your readers that these proportions are of no importance whatever, and that the alkali may be omitted without therapeutical loss, and with much practical convenience.

“For the last five years of my practice I ceased entirely to use the alkali, and my results were equally good. The mistakes and failures in treating adolescent and chlorotic anæmias are often due to the prevailing economy in the use of the iron. With five or even ten grain doses of citrate of iron little real progress may be made in many cases. No form of iron is so efficient as the sulphate, of which gr. j. thrice daily is to be given for a week, then two grain doses for ten days, and so on till nine, or or even twelve grains are taken in the day. The drug should be gradually reduced in like manner, and the course should never be less than three months in duration, or relapses may occur. In obstinate cases, the addition of one-thirtieth grain of strychnine, or one-quarter grain of phosphide of zinc are invaluable aids. Most patients require the inclusion of one-third to one-fourth grain of extract of aloes to prevent the constipating effect of the sulphate, but Dr. Mackenzie rightly denies that constipation is the cause of chlorosis, or even generally coincident with it. This error is due to reasoning from an insufficient number of careful records.

“Iron pills should be carefully made from the dried sulphate, and not with gums, which, by hardening, make the pills insoluble. In any case it is better to order the pills to be freshly made every week, if not even more frequently. Patients who are unable to take pills are best treated with the saccharated carbonate of iron, of which three or four large teaspoonfuls may be given in the day.”—*Dr. T. C. Allbutt, in Brit. Med. Journal.*

**DIPHThERIA.**—I should like to put on record a method which I have found exceedingly useful in the treatment of diphtheria ; it consists in the hourly spraying of the fauces and naso-pharynx with a saturated solution of baborate and bicarbonate of soda (about forty grains of each to the ounce of water). The *rationale* of the thing is, I believe, that the bicarbonate of soda tends to loosen and liquefy the tenacious mucus which is always present in these cases, and thus allow the borax to exert its action as an antiseptic ; it is of course a weak antiseptic, but it has the advantage of being compatible with the bicarbonate, which I believe plays an important part as I have said above.

I have not the smallest doubt, in my own mind, that it tends to shorten the course of the disease ; in fact, in one case the recovery was so rapid that I should have doubted my diagnosis if it had not been that a sister of the patient, who was living in the same house, had just died of the disease in St. George's Hospital.

In severe cases it is well to spray up the nostril to prevent the membrane spreading upwards, but for this the solution should be diluted, for if it is saturated with the alkali it causes hyperemia and soreness of the mucous membrane.

In justice to Dr. Fenwick, I must say that in all my cases I have given iron.

It is now nearly two years since Dr. Coall mentioned the line of treatment to me ; he tells me that he had used it for several years previously—in fact, it is to him that the credit is altogether due if the method should prove useful after a more extended trial.—*Vernon Jones, M. D., in British Medical Journal.*

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**THE ÆTIOLOGY OF DIPHTHERIA.**—In the *Johns Hopkins Bulletin*, Dr. W. H. Welch gives the latest results of the researches on this point and adds from his own studies still other observations. From all this he concludes it is fully proved that the specific primary cause of diphtheria is the Klebs-Löffler bacillus. This organism he calls the *bacillus diphtheriæ*. This bacillus is present in every case of primary diphtheria in such number and situation as to explain the local manifestations of the disease. It

can be isolated in pure culture readily, and a disease identical in all respects with human diphtheria can be produced experimentally by the inoculation of pure cultures. Thus we are in possession of positive means for making a diagnosis of diphtheria. The method of doing this is not difficult and can readily be applied, though it may be questioned whether many practitioners are likely to make use of these means. We are taught that there are pseudo-membranous anginas which must be separated from etio-logically pure diphtheria, and that diphtheria may exist in extremely mild forms even without visible pseudo-membranous deposits. The endless controversy as to whether diphtheria is primarily a local or general disease is settled. It is primarily local, the grave constitutional symptoms are the result of intoxication with poisonous products formed by the local action of the bacilli. We can study the varied effects produced upon the animal body by the specific toxic products of the diphtheritic germ. We can separate the alterations belonging to the disease itself from the many complications of the disease. Intelligent measures of prophylaxis can be based upon a definite knowledge of the characters of the specific germ and its behavior in the body. Rational indications for treatment can be established, and have been formulated.—*American Lancet*.

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PROSTITUTION.—In Vienna each prostitute receives a book containing a description and photograph of herself, and a copy of the laws relating to prostitution. No one under sixteen can be registered, nor persons afflicted with organic or constitutional disease. Sanitary examinations are made twice a week, all diseased women are put into hospitals, primary syphilitic cases are quarantined for three months, and kept under treatment for two years. Clandestine prostitutes are treated in the same way by their own physicians.

In France, M. Commenge recently stated, at a meeting of the Academy of Medicine of Paris, that he had collected the statistics of the number of diseased prostitutes found in the decade from 1878 to 1887 : First, among women registered by houses or cards; second, among those women that—though registered—

were the objects of more or less frequent arrests, and constituted a special class under the name of *femmes du depot*; third and lastly, among the uninspected, or women that lived by clandestine prostitution. The result obtained, based on nearly a million visits, showed the number of cases of syphilis in each thousand examined to be respectively 3.1, 2.7 and 23.9. Of other venereal diseases 3.0, 2.4 and 14.5.

It is only by the accumulation of such statistics that the fanatical sentiment against the regulation of prostitution can be overcome and the health of innocent women and children protected.—*Boston Med. and Surg. Jour.*

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PLACENTA PRÆVIA.—Braxton Hicks lays down the following rules as regards treatment:

1. The diagnosis of placenta prævia once established you must terminate labor with the least possible delay.
2. When the operation has been commenced you must not leave your patient until it is completed.
3. When the cervix is completely dilated and the placenta is marginal, it is necessary to break the membranes, and see whether the head is pushed toward the neck during the pains.
4. If the head descends slowly, employ the forceps or perform version.
5. If the os is small and is more or less covered by the placenta, the latter should be cautiously detached around the whole circumference of the os. If there is no hæmorrhage delay of one or two hours is permissible. If the os is not dilated and if you have no dilator at hand, you may dilate the cervix manually. If you think that the forceps may be easily applied, it is well to apply them. If not it is necessary to do bi-polar version by the combined internal and external method. The cervix is thus tamponned by the legs or breach of the child. After this the treatment is the same as for any case of foot or breach presentation.
6. If the neck is small, and if you have neither forceps nor dilator, version must be done.

7. If during the manœuvres here mentioned, a violent hæmorrhage occurs version must be terminated by extraction of the fœtus.

8. When the fœtus is dead, or when labor comes on before the end of the seventh month, it is necessary to do version and leave the rest to nature.—*L'Union Med.*—*West Med. Review.*

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THE SPEEDY CURE OF TONSILLITIS.—The *London Medical Recorder* contains the following prescription for the rapid relief of tonsillitis:

R Tinc. of veratrum viride, 30 minims.  
Sulphate of morphia,  $1\frac{1}{2}$  grains.  
Distilled water, 6 drachms.

M.—Dose, one teaspoonful, given twice, with one hour's interval at the outset of the treatment, and then at intervals of two or three hours, as may be required.

The author of the treatment holds that there is some kind of therapeutical agreement or harmony between the drugs, when used together, which gives them an efficiency not possessed by either of them when used separately. For example, the liability to nausea from either of them alone is greatly modified by the combination. He refers to a number of cases in which this treatment has seemed to produce unusually prompt relief, and he asserts that he knows of no drug or drugs which have the power to control tonsillar inflammation with the certainty and celerity of those agents when used jointly.—*Ex.*

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FRACTURE OF THE SHAFT OF THE FEMUR.—At the last meeting of the American Surgical Association a committee, consisting of Dr. Stephen Smith, of New York; Dr. Agnew, of Philadelphia; Dr. Parkes, of Chicago; Dr. Cheever, of Boston; Dr. McGuire, of Richmond, and others, made a report on "What should be considered satisfactory results in the treatment of fracture of the shaft of the femur?" Following is a summary of their report:

*Conclusions.*—A satisfactory result has been obtained in the treatment of fracture of the shaft of the femur when—

1. Firm bony union exists.
2. The long axis of the lower fragment is either directly continuous with that of the upper fragment or the axes are on nearly parallel lines, thus preventing angular deformity.
3. The anterior surface of the lower fragment maintains nearly its normal relation to the plane of the upper fragment, thus preventing undue deviation of the foot from its normal position.
4. The length of the limb is either exactly equal to that of its fellow, or the degree of shortening falls within the limits found to exist in 90 per cent. of healthy limbs, viz., from one-eighth of an inch to one inch.
5. Lameness, if present, is not due to more than one inch of shortening.
6. The conditions attending the treatment prevent other results and those obtained.—*Medical News.*

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RECENT RECIPES FOR GONORRHŒA—Brindisi (*Rev. Gen. de Therap.*) employs the following anti-septic injection ;

℞. Antipyrin.....gr. xlv.  
 Sulphate of zinc.....gr. iv.  
 Rose water.  
 Cherry-laurel water.....aa ʒij. Mix.

Dr. William B. Dewees, of Salina, Kan., says (*Kan. Med. Jour.*) few cases will remain uncured after eight days' use of injection of

℞. Sodium biborat.  
 Resorcin.....aa ʒss.  
 Glycerin.....ʒiiss.  
 Rose water, q. s.....ʒviiij.

M. S.—Inject ʒij every two hours the first day; then lengthen intervals as the discharge lessens. After third day, take internally,

tincture *Canabis indica*, 5 drops every three hours. Bathe glans penis in as hot water as can be borne three times daily.

Dr. Richard Lee (*Intern. Surg. Jour.*, August, 1891) first uses warm injections of sodium biborate and morphia [sulph.] (in glycerin and rose water) for three days; and then *aristol* in liquid vaseline—25 grains to ounce. Prompt relief without relapse was effected in from four to six days.—*Virginia Medical Monthly*.

**TREATMENT OF EPILEPSY.**—Under this head Poulet, in *Bulletin Generale de Therapeutique*, writes of a combination of bromide potassium with calabar bean, which has given him success in the treatment of obstinate cases of epilepsy where the bromides alone had failed. A favorite formula of his is :

R. Bromide of potassium,	. . .	100 parts.
Tincture of calabar bean,	. .	35 “
Water,	. . . . .	470 “

Sig: A tablespoonful, to be increased to a tablespoonful and a half, then two tablespoonfuls, daily.

A tablespoonful contains about 57 grains of bromide, and about 16 minims of the tincture. The medicine may be given in divided doses instead of in one full dose, half a teaspoonful being given at first twice, then three times, then four times a day.

Poulet reports five obstinate cases treated in this manner. These were cases where bromide alone failed to cure.

Poulet terminates his article by the following conclusions:

The bromides remain the sheet anchor in the treatment of epilepsy—and by the term “bromides” we have especial reference to the bromide of potassium, which alone is truly efficacious.

There are, however, a great many epileptics whose attacks are only mitigated or postponed, not completely suppressed, by bromide of potassium.—*Times and Register*.

**THERE** are 2,500 licensed physicians in New Jersey, and of these there are said to be ten per cent. registered on bogus or fraudulent diplomas.



## BRONCHIAL ASTHMA.

- R. Iodine of ammonium, dr. ij.  
 Fl. ext. grindelia robusta,  $\text{ʒss}$ .  
 Fl. ext. glycyrrhiza, dr. iv.  
 Tinct. lobelia,  
 Tinct. belladonna, aa dr. ij.  
 Syr. tolu, q. s. ad.  $\text{ʒiv}$ .

Dose.—Teaspoonful three times a day; extra doses during a paroxysm.

This formula may be varied to suit indication. I have cured many cases of asthma by means of it, some of over twenty years' standing, myself among the number.—*Dr. Covert in American Medical Journal.*

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ROUGH AND READY TEST FOR CANCER.—Mr. H. J. Stites, of Edinburgh, proposes the following as a quick method of diagnosis for carcinoma at the operating table: 1. Excise the mamma. 2. Wash thoroughly in water to remove blood. 3. Place in a five per cent. solution of nitric acid for ten minutes. 4. Wash in cold water for five minutes. By the time these procedures are executed the axilla is cleaned out and the vessels tied. The mamma is now examined. The carcinomatous structure appears a dull white, like the eye of a boiled fish; the healthy tissue translucent. When such reaction is seen, additional tissue should be removed at the corresponding point.—*Journal American Medical Association.*

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DIED.—In Augusta, Ga., December 15, ult., Dr. Henry T. Campbell, aged sixty-eight. The Georgia profession has sustained a great loss in the death of this excellent physician and estimable gentleman. Dr. Campbell was once Professor of Anatomy and Surgery in the New Orleans Medical College and in 1885 was president of the American Medical Association. At the time of his death he was Professor of Surgery and Gynecology in the Augusta Medical School. In spite of a large practice he made frequent and valuable contributions to medical literature.

## THE INTERNATIONAL EXECUTIVE COMMITTEE OF THE PAN-AMERICAN MEDICAL CONGRESS.

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The Committee on Organization of the Pan-American Medical Congress at its meeting at St. Louis last October elected the following International Executive Committee: The Argentine Republic, Dr. Pedro Lagleyze, Buenos Ayres; Bolivia, Dr. Emilio Di Fomassi, LaPaz; Brazil, Dr. Carlos Costa, Rio de Janeiro; British North America, Dr. Jas. F. W. Ross, Toronto; British West Indies, Dr. James A. DeWolf, Port of Spain; Chili, Dr. Moises Amaral, Santiago; United States of Columbia, Dr. P. M. Ibanez, Bogota; Costa Rica, Dr. Daniel Nunez, San José; Ecuador, Dr. Ricardo Cucalon, Guayaquil; Guatemala, Dr. José Monteris, Guatemala Nueva; Hayti, Dr. D. Lamothe, Port au Prince; Spanish Honduras, Dr. George Bernhardt, Feguagalp; Mexico, Dr. Fomas Noriega, City of Mexico; Nicaragua, Dr. J. I. Urtecho, Grenada; Peru, Dr. J. Casamira Ulloa, Lima; Salvador, Dr. David J. Guzman, San Salvador; Spanish West Indies, Dr. Juan Santos Fernandez, Habana; United States, Dr. A. Vanderveer, Albany, N. Y.; Uruguay, Dr. Jacinto DeLeon, Montevideo; Venezuela, Dr. Elias Rodenguez, Caracas.

Hiwail, Paraguay, Santo Domingo, the Danish, Dutch and French West Indies are not yet organized. Nominations of local officers have been received from a majority of all the members of the International Executive Committee and a number of the lists have been confirmed by the Committee on Organization. These will be announced as rapidly as acceptances are examined.

CHARLES A. L. READ,  
Secretary-General.

Cincinnati, January 15, 1892.

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**REMEMBER IN PRESCRIBING IRON.**—That it has never been proved that salts of iron are absorbed in the intestinal canal.

That there is considerable evidence to the contrary.

That however minute the dose of iron administered, the stools are invariably blackened by reduction of the iron to the state of

sulphide, which is insoluble in the alkaline of neutral intestinal juices.

That there is a very general opinion in favor of the old-fashioned perchloride of iron in cases where iron is indicated.

That this opinion is undoubtedly proven by long experience, and that no other inorganic preparation of iron gives better results *where tolerated*.

That the effect of perchloride of iron is *not* proved to depend on the iron at all, and that it is probably due chiefly to the mineral acids, which are always present in tincture, or solution of perchloride of iron.

That a neutral solution of perchloride of iron is not permanent, and cannot be used in pharmacy.

That the neutral proto or perchloride, carbonate, sulphate, phosphate, and all other salts of iron, not excepting the so-called albuminates, peptonates, and dialyzed preparations of iron, cannot be relied on to give as good results as the perchloride.

That Sir Andrew Clark has long held that constipation, when complicated with anæmia, is due to the decomposition of food (and with it the iron compounds), with absorption of ptomaines, which produce a continuous toxic effect and enfeeble the red blood corpuscles, besides depriving them of their natural source of iron, which is necessary to maintain their normal oxygen-bearing power.

That if iron be administered at all, the salts of iron should be rigorously avoided, as they are liable to intensify the anæmia, rather than do good, besides blackening the teeth, and frequently disagreeing with the patients.

That hemoglobine (Ferrum Sanguinis) is an ideal hæmatinic, it *does not blacken the stools* (thus proving its assimilation), and is the most prominent ferruginous element of our food in a very concentrated form.

That Ferrum Sanguinis is a dry, semi-crystalline powder isolated from bullock's blood; this is soluble in water, but is best dispensed in small spherical capsules (Chapoteaut) of twenty centigrammes each, which is equivalent to one milligramme of metallic iron.—*St. Louis Medical and Surgical Journal*.

## Medical Items.

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RECENT legislative enactments in Arkansas mention eight instances of unprofessional conduct which warrant the revocation of the physician's license. These are:

1. Procuring or aiding and abetting in the procuring of criminal abortion.
  2. Employing or using what are known as cappers, steerers, or drummers, or the subsidizing of hotels or boarding-houses to procure practice.
  3. The obtaining of a fee on the assurance that a manifestly incurable disease can be permanently cured.
  4. The wilful betrayal of a professional secret to the detriment of a patron.
  5. All advertisements of medical business in which untruthful and improbable statements are made.
  6. All advertisements of any medicine or means whereby the monthly periods of women can be regulated or the menses re-established.
  7. Conviction of any offence involving moral turpitude.
  8. Habitual drunkenness.—*Med. Record.*
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THE College of Physicians of Philadelphia announces that the next award of the Alvarenga Prize, being the income for one year of the bequest of the late Senor Alvarenga, and amounting about one hundred and eighty dollars, will be made on July 1, 1892. Essays intended for competition may be upon any subject in medicine, and must be received by the secretary of the college on or before May 1, 1892. It is a condition of competition that the successful essay or a copy of it shall remain in possession of the college. CHARLES W. DULLES, Secretary.

Dr. J. B. S. Holmes has associated with him at his Sanitarium, Dr. W. E. B. Davis, recently of Birmingham, Ala. Dr. Davis is president of the Tri-State Medical Society of Alabama, Georgia and Tennessee; secretary of the Southern Surgical and Gynecological Society; vice-president of the American Medical Association; member of the Birmingham Board of Medical Examiners; surgeon to the Birmingham Hospital of United Charities and is one of the brightest, most prominent and most promising surgeons in the South. He has already made considerable fame for himself in gynecological and abdominal surgery.

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Dr. Hudson, class of '86, Atlanta Medical College, and second honor man, passed through Atlanta recently on his way to Europe. He will spend several months there and has promised to write monthly letters to THE JOURNAL upon interesting medical subjects. Knowing Dr. Hudson's ability we can promise our readers something excellent in these letters.

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At the next commencement of the Southern Medical College, March 3, an Alumni Association of the college will be organized with permanent headquarters in Atlanta. It is hoped by those undertaking this work that all alumni of the college will be present, who can do so, to assist in the organization. Those who expect to come will please communicate with Dr. J. W. Price, West End, Atlanta, Ga.

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On January 14th, Dr. J. A. Childs, of Atlanta, was married to Miss Susie Pittman, also of Atlanta. THE JOURNAL extends to the happy pair its good wishes and congratulations.

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THE *Therapeutic Gazette* is now to be edited by Drs. Hobart A. Hare, Geo. A. de Scheveinitz and Edward Martin, all of Philadelphia.

## Book Reviews.

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**AN ABSTRACT OF THE SYMPTOMS**, with the Latest Dietetic and Medical Treatment of Various Diseased Conditions. New York. Reed and Carnrick.

This convenient and useful little book contains a great deal of valuable information, particularly with reference to the dietary of the sick. Of course the preparations of this manufacturing house are given considerable prominence. In Part I. concise outlines of the leading symptoms of the common diseases are presented, also the dietetic and medicinal treatment that is most effectual in relieving or curing these abnormal conditions. Part II. is an excellent contribution to the subject of the physiology of digestion and assimilation, and deserves a careful reading.

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**INTERNATIONAL CLINICS:** A Quarterly of Clinical Lectures October, 1891. J. B. Lippincott Company, Philadelphia.

This is the third volume of a valuable publication which has been favorably noticed before in this journal. The present fully sustains the excellence of those which have preceded it, and, like the others, furnishes clinical lectures in nearly every department of medical and surgical practice.

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**MEDICAL REVIEW VISITING LIST.**—St. Louis, Mo., J. H. Chambers & Co.; price 75 cents.

This book contains a perpetual visiting list with a pocket reference book. The pages for weekly call and memoranda are ample and the tables for ready reference are both valuable and convenient.

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The St. Louis *Medical Review* comes out for 1892 in a new attire, under the editorial control of Dr. A. H. Ohmann-Dumesnil. Many have been the changes in the staff of the *Review* during the year just past. The present management seems to have struck out on a new line, and we wish for it a long and abiding success.

ST. LOUIS is nothing if not prolific in medical journals. On January first the *Medical Fortnightly* appeared, under the editorship of Dr. Bransford Lewis. The first issue of the *Fortnightly* is very creditable. The matter is good and the printers' work is very well executed. The *Fortnightly* is seized in the beginning with the high and noble ambition of trying to pacify the discordant elements of the St. Louis profession. This is an undertaking as praiseworthy as it is immense. The *Fortnightly* will proceed to be a "magnet which will draw together into happy and felicitous union this array of otherwise-divided medical teachers."

The names of several of the St. Louis brethren are harmoniously commingled among the collaborators of the *Fortnightly*, and we presume they are now working together with unity of spirit and purpose. It is a blessed thing for brethren to dwell together in unity. Let us all pray!

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ONE of the most interesting and excellent periodicals that is gotten out by the enterprise and competition of American publishers is Lippincott's Magazine. For a quarter of a century it has enjoyed the patronage and esteem of a large number of readers, and to-day it is easily one of the best of our literary monthlies. The characteristic feature of this magazine is the appearance, in every issue, of a complete novel, by some prominent living author. In recent numbers these have been furnished by Julian Hawthorne, Edgar Fawcett, Lloyd Brice, Mrs. Alexander, Rudyard Kipling, and others of equal note. This year the magazine will contain novels by Marion Harland, Capt Chas. King, Frances Courtenay Baylor, Amelia Barr and others.

In addition to this, a most valuable feature will be a series of articles dealing with reminiscences of men famous in our political history, as, Abraham Lincoln, Jno. C. Calhoun, Andrew Johnson, etc. "Lippincott's" deserves the cordial patronage and appreciation of all lovers of good literature.

AUG 5 1912

